

Prevention Organizational Systems AIDS Care and Treatment Project – Pro-ACT, Nigeria

Quarterly Progress Report, January – March, 2016

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To build the capacity of Nigeria’s public, private and community sectors for sustainable HIV/AIDS and TB prevention, control, care and treatment integrated with the health system

5 Key Words: HIV/AIDS, Capacity, Nigeria, ProACT, Tuberculosis, TB, Prevention

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**Leadership, Management and Sustainability Program,
Nigeria
PREVENTION ORGANIZATIONAL SYSTEMS AIDS
CARE AND TREATMENT PROJECT
(Pro-ACT)**

Quarterly Report

Quarter 2 – January 1 to March 31, 2016



Submission Date: April 29, 2016

Agreement Number: AID-620-A-00-09-00013-00

Activity Start Date and End Date: July 16, 2009 to November 14, 2016

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Acronyms

3TC	Lamivudine
ABC	Abacavir
ACT	AIDS Care and Treatment Project
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal care
APR	Annual progress report
ART	Anti-retroviral Therapy
ARV	Anti-retroviral
AZT	Azidothymidine (Zidovudine)
CCT	Comprehensive Care and Treatment
CE	Continuing Education
CHEW	Community Health Extension Worker
CME	Continuing Medical Education
COP	Country Operational Plan
CPHCE	Centers for Health Professional Continuing Education
CQI	Continuous Quality Improvement
CSO	Civil Society Organization
CTX	Cotrimoxazole
DHIS	District Health Information System
DOTS	Directly Observed Therapy Short Course (for TB)
DQA	Data Quality Assurance
e-NNRIMS	Electronic Nigeria National Response Information Management System
EID	Early Infant Diagnosis (for HIV-Infection)
EMR	Electronic Medical Record
EMRS	Electronic Medical Record System
FMoH	Federal Ministry of Health
FY	Fiscal Year
GBV	Gender Based Violence
GH	General Hospital
GOPD	General Outpatient Department
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HTC	HIV Testing and Counseling
HRH	Human Resources for Health
HRIS	Human Resources Information System
IC	Infection Control
IPs	Implementing Partners
IPT	Isoniazid Preventive Therapy
IR	Intermediate Result
IT	Information Technology
JSI	John Snow, Inc.
LACA	Local Action Committee on AIDS
LGA	Local Government Area
LGQIT	Local Government Quality Improvement Teams
LMS	Leadership, Management and Sustainability Program
LRF	Laboratory Revolving Fund

LTFU	Lost to follow-up
M&E	Monitoring and Evaluation
MoH	Ministry of Health
MSH	Management Sciences for Health
MTCT	Mother-to-child transmission
NACA	National Agency for Control of AIDS
NEPWHAN	Network of People Living with HIV/AIDS in Nigeria
NNRIMS	Nigerian National Response Information Management System for HIV/AIDS
NIPOST	Nigeria Postal Services
NVP	Nevirapine
OVC	Orphans and Vulnerable Children
PCR	Polymerase Chain Reaction
PEPFAR	US President's Emergency Plan for AIDS Relief
PHC	Primary Health Centre
PHDP	Positive Health, Dignity Prevention
PITC	Provider-Initiated Testing and Counseling
PMTCT	Prevention of Mother-to-Child Transmission (of HIV)
Pro-ACT	Prevention Organizational Systems AIDS Care and Treatment Project
PLHIV	People Living with HIV/AIDS
QA	Quality Assessment
QI	Quality Improvement
RADET	Retention and Audit Determination Tool
RTKs	Rapid Test Kits (for HIV)
SACA	State Agency for Control of AIDS
SAPR	Semi-Annual Progress Report
SCMS	Supply Chain Management System
SIMS	Site Improvement through Monitoring Systems Tool
SLA	Savings and Loans Association
SLMTA	Strengthening Laboratory Management Towards Accreditation
SMoH	State Ministry of Health
SOP	Standard Operating Procedures
SPEEiD	Strengthening the Processes and Effectiveness of Early Infant Diagnosis
SSL	Sustained Response LGAs
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TA	Technical Assistance
TB	Tuberculosis
TDF	Tenofovir
TWG	Technical working group
UDUTH	Usman Danfodio University Teaching Hospital
USAID	United States Agency for International Development
UITH	University of Ilorin Teaching Hospital
USG	United States Government
VL	Viral Load
VSLA	Village Savings and Loan Association
WHO	World Health Organization

Financial Report

Quarterly Progress Report (January – March 2016)

ACTIVITY SUMMARY
Implementing Partner: Management Sciences for Health
Activity Name: Leadership Management Sustainability – Prevention organizational systems AIDS Care and Treatment Project (Pro-ACT), Management Sciences for Health (MSH)
Activity Objective: To build the capacity of Nigeria’s public, private and community sectors for sustainable HIV/AIDS and TB prevention, control, care and treatment integrated with the health system
The Activity’s intermediate results are: <ol style="list-style-type: none">1. Strengthened CSO and community structures for sustained HIV/AIDS & TB services2. Sustained access to quality integrated HIV/AIDS and TB services and products3. Strengthened public and private sector to increase demand for HIV/AIDS and TB services and interventions, especially among target groups.
USAID/Nigeria SO: SO 14
Life of Activity (start and end dates): July 16, 2009 – November 14, 2016
Total Estimated Contract/Agreement Amount: \$85,022,571.00
Obligations to date: \$81,305,044.99
Current Pipeline Amount: \$8,213,486.87
Accrued Expenditures This Quarter: \$2,954,582.47
Activity Cumulative Accrued Expenditures to Date (March 31st): \$73,091,558.12
Estimated Expenditures Next Quarter: \$2,779,781.28
Report Submitted by: Med Makumbi, Chief of Party Submission Date: 4/29/2016

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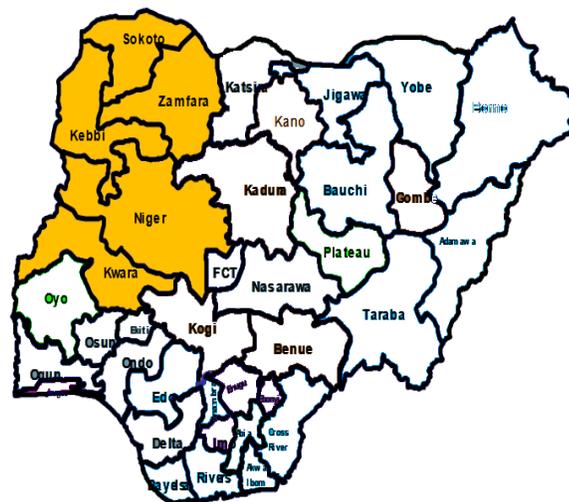
I. PROGRAM OVERVIEW/SUMMARY

Program Name:	Prevention Organizations Systems AIDS Care and Treatment Project
Activity Start Date And End Date:	July 15, 2009 – November 14, 2016
Name of Prime Implementing Partner:	Management Sciences for Health
[Contract/Agreement] Number:	620-A-00-09-00013-00
Major Counterpart Organizations	Government of Nigeria: FMOH, SMOH, NACA, SACA
Geographic Coverage (cities and or countries)	Niger, Kwara, Kebbi, Sokoto and Zamfara states
Reporting Period:	Jan – March 2016

I.1 Program Description/Introduction

MSH’s Leadership, Management and Sustainability Program (LMS) is a global five year USAID funded Cooperative Agreement designed to develop leadership and management skills at all levels of healthcare organizations and programs to effectively address change and improve health outcomes in the areas of family planning, reproductive health, HIV and AIDS, infectious disease, and maternal and child health. In Nigeria, the LMS Program implements the Prevention Organizational Systems AIDS Care and Treatment Project (LMS Pro-ACT), a PEPFAR funded associate award with the goal of building the capacity of Nigeria’s public, private, and community sectors for sustainable HIV, AIDS and Tuberculosis (TB) prevention, control, care, and treatment. LMS Pro-ACT began operations in August 2009 taking over from the AIDS Care and Treatment (ACT) Project that started in October 2007.

The goal of Pro-ACT is to build the capacity of Nigeria's public, private and community sectors for sustainable HIV/AIDS and TB prevention, control, care, and treatment integration within the health system. The project was initially a five year project and up until July 2013 partnered with six state governments in Kogi, Niger, Kwara, Kebbi, Adamawa, and Taraba states, to support the delivery of comprehensive HIV services at 30 treatment centers. In August 2013 the project received a modification which extended its life by one year and changed the geographical focus to the five states of Niger, Kwara, Kebbi, Sokoto, and Zamfara. Pro-ACT has subsequently received additional extensions which changed the



end date to July 2015, then to November 2015 and most recently November 2016. Pro-ACT now supports 41 comprehensive HIV and AIDS treatment centers. The project is implemented by Management Sciences for Health (MSH), with a main office in Abuja, and offices in each of the 5 states that bring technical support closer to the areas of greatest need.

The project's interventions are organized in accordance with the 3 intermediate result (IR) areas:

- IR 1. Strengthened CSO and community structures for sustained HIV/AIDS and TB services
- IR 2. Sustained access to quality integrated HIV/AIDS and TB services and products
- IR 3. Strengthened public/civil society organizations (CSO) and community enabling environments

1.2

Summary of Results to Date

Performance Indicators	Annual Cumulative Planned Target	Annual Cumulative Actual	Q1	Q2	Q3	Q4	Annual Performance Achieved through the End of the Reporting Period (in %)	On Target Y/N
# of new ANC and Labor & Delivery clients	146,922	102003	49269	52734			69%	Y
# of pregnant women with known HIV status (includes women who tested for HIV and received their results)	122,435	92987	45932	47055			76%	Y
# of pregnant women tested positive to HIV (including known positive)	1,516	1262	626	636			83%	Y
Known	688	558	256	302			81%	Y
New	828	704	370	334			85%	Y
# of HIV positive pregnant women who received anti-retrovirals to reduce risk of mother-to-child transmission (Numerator)	1,437	1166	592	574			81%	Y
New Lifelong ART	111	46	25	21			41%	N
Already on ART	211	488	238	250			231%	Y
Maternal Triple ART	1,115	635	329	306			57%	Y
# of infants born to HIV positive pregnant women who received an HIV test within 12 months	1,437	762	361	401			53%	y

< 2 Months	551	173	63	110			31%	Y
2-12 Months	886	589	298	291			66%	Y
# of exposed babies delivered by HIV positive mother	0	1027	508	519			N/A	
# of exposed infants who received prophylaxis after delivery	0	868	479	389			N/A	
% of infants born to HIV positive pregnant women who received an HIV test within 12 months	0	74%	71%	77%			N/A	
# of infants born to HIV infected women who were started on cotrimoxazole (CTX) prophylaxis within two months of birth within the reporting period	1293	614	407	207			47%	Y
Output: Number of individuals who received testing and counseling services for HIV and received their test results (including PMTCT)	273,522	213554	110329	103225			78%	Y
Output: Number of individuals who were tested positive to HIV (including PMTCT)	8,913	7063	3551	3512			79%	Y
PMTCT	1,516	1262	626	636			83%	Y
HTC Sites only	7,027	5578	2809	2769			79%	Y
TB Setting	370	181	89	92			49%	N
Early Infant Diagnosis		42	27	15			N/A	
Output: Number of individuals who received testing and counseling services for HIV and received their test results (HTC sites only)	151,979	117913	63064	54849			78%	Y
# of HIV positive adults and children who received at least one of the following during the reporting period: clinical assessment (WHO staging) OR CD4 count OR viral load (Direct Service Delivery)	31,150	26327	21312	26327			85%	Y

# of HIV infected adults and children newly enrolled in clinical care during the reporting period and received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	6,138	4564	2039	2525			74%	Y
# of PLHIV who were nutritionally assessed via anthropometric measurement (Numerator)	16,590	0	0	0			0%	N
# of clinically malnourished PLHIV who received therapeutic and/or supplementary food during the reporting period(Numerator)	607	0	0	0			0%	N
# of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS	18,342	8499	2428	6071			46%	N
# of active beneficiaries receiving support from PEPFAR OVC programs to access HIV services	5,184	5391	426	4965			104%	Y
# of individuals who received care and treatment for HIV and received their test results at a USG supported TB service outlet (including suspects)		2450	1137	1313			N/A	
# of HIV positive patients who were screened for TB in an HIV care or treatment settings (Numerator)	30,538	20625	16281	4344			68%	Y
# of registered TB cases with documented HIV positive status who start or continue ART during the reporting period (Numerator)	355	186	75	111			52%	Y
# of registered new and relapse TB cases with documented HIV positive status during TB treatment during the reporting period (Denominator)	508	312	125	187			61%	Y
# of registered new and relapsed TB cases with documented HIV status, during the reporting period (Numerator)	2211	1465	645	820			66%	Y

# of registered new and relapsed TB cases, during the reporting period (Denominator)	2457	1641	688	953			67%	Y
# of PLHIV newly enrolled in HIV clinical care (as defined in the denominator) who start IPT and receive at least one dose, during the reporting period (Numerator)	1657	1742	1124	618			105%	Y
# of adults and children who are still alive and on treatment at 12 months after initiating ART (Numerator)	4,933	2038	0	2038			41%	N
# of adults and children who initiated ART in the 12 months prior to the beginning of the reporting period, including those who have died, those who have stopped ART, and those lost to follow-up.	5,802	3112	0	3112			54%	Y
% of adults and children who are still alive and on treatment at 12 months after initiating ART(Numerator)	85%	65%					65%	N
# of adults and children with advanced HIV infection newly enrolled on ART	4,910	3842	1864	1978			78%	Y
# of adults and children with advanced HIV infection receiving antiretroviral therapy (ART) [CURRENT]	24,922	30262	29163	30262			121%	Y
# of people receiving post-GBV care	373	6	0	6			2%	N
# of people completing an intervention pertaining to gender norms, that meets minimum criteria	4233	1319	0	1319			31%	N

Note: The Results Performance Column depicts level of achievement expressed as a percentage of Actual versus Planned.

2. ACTIVITY IMPLEMENTATION PROGRESS

The MSH Pro-ACT project is in its final year of programming with an end date of November 2016. The PY6 work plan has been aligned with the guidelines of PEPFAR Nigeria COP15 strategic shift and the overall goal of PEPFAR 3.0 which stipulates ***doing the right things, at the right time and right places***. For FY16 Q2 and SAPR, Pro-ACT is reporting achievements in 161 sites following the transitioning of 37 PMTCT sites at the end of FY15, which reduced the total number of MSH supported sites from 198 to 161. In FY16, Pro-ACT will continue to support sustained access to quality HIV and TB services across 58 sustained response LGAs in the five focus states, with overall project support focused mainly on health facility based targeted testing and passive enrollment.

Key achievements from the reported quarter include:

- 31 low yield PMTCT sites were transitioned to State Governments
- 100,884 clients were counseled and tested (including tests at PMTCT sites)
- 4,807 OVCs and their caregivers received services through the 9 civil society organization (CSO) sub grantees
- 94% (129/137) of identified pediatric clients were commenced on ART
- ART and pharmacy registers were reconciled across the 41 facilities resulting in improvement of patient retention figures from 62% to 65% through thorough triangulation and tracking
- 530 patients who had initially defaulted on their clinical appointments were tracked and brought back into care
- Kwara and Zamfara states procured HIV test kits (2,900 tests) to complement PEPFAR supplies
- The EMR system went live in the three facilities: UITH, UDUTH and GH Minna

In Q2, HTC services across the 41 MSH supported sites were delivered in line with the USG/PEPFAR guidance for implementing partners (IPs) working in the sustained response LGAs (SSL) which provides only for targeted testing, passive enrollment and discontinuation of all demand generation activities. To ensure continued adherence to this significant shift, in the quarter under review, MSH worked with state partners and facility teams to reorganize the delivery of HTC services, through the deployment and use of rapid test kits (RTKs) donated by the state government to PEPFAR non-priority testing points. In Q2, a total of 100,884 persons were counseled and tested. This is slightly lower than the total number of persons counseled and tested in Q1 (109,836 clients including children and pregnant women).

Over the second quarter of FY16, the gradual transition of the second group of 31 low yield PMTCT sites (with only 5-11 positive clients identified within a 12 month period) was completed by the end of March 2016, with continued support to be further provided by the State Ministries of Health (SMoH). This remains in keeping with the directive from PEPFAR, for the first group of 37 lower yield PMTCT sites (0-4 positive clients tested within a 12 month period) that had transitioned by the end of September 2015.

The project's main focus in this reporting period was addressing poor client retention rates in the 41 partner hospitals, with priority on the most challenged facilities. This ongoing effort to address retention gaps across partner hospitals is building on the successes of the site specific interventions initiated in Q1. A preliminary review of data reveals that some tangible results were achieved by the end of the quarter.

For example, in Kwara state, the average retention rate improved from 69% to 73% at the time of the semi-annual progress report (SAPR) 16. The project has a set target to achieve an 80-85% retention rate across all 41 partner hospitals by the time of the annual progress report (APR) 16.

Some of the strategies employed to improve retention include: Identification and engagement of trackers and patient escorts, accelerated physical tracking of defaulters using mobile technology, improvement of service data documentation, linking of newly enrolled and existing HIV positive clients to peer support groups, clustering of patients living in the same localities for easy follow up and making use of customized retention support tools like the retention calendars and tracer cards.

In this quarter, MSH continued work towards the graduation of 30% of the enrolled 18,342 OVC caseload by the end of FY16 (September 30, 2016). To achieve this, a total of 3,464 households of vulnerable children were reassessed across the five focus states in the quarter under review and stratified into Vulnerable, More Vulnerable and Most Vulnerable to inform ongoing graduation activities and efforts, in line with USG COP15 directive.

In line with current UNAIDS 90:90:90 goals, the PEPFAR support for the scale-up of viral load testing as recommended by WHO 2013 Guidelines with aim of demonstrating epidemic control, MSH worked to deploy innovative approaches aimed at optimizing viral load test uptake at the Usmanu Danfodiyo University Teaching Hospital (UDUTH), through monthly service data analysis, setting a quarterly testing target, and addressing clinical systems barriers that continue to impact access for HIV positive clients. During the quarter, a total of 439 patients on ART received viral load tests in the UDUTH lab, of whom 250 (57%) were found to be virally suppressed.

The MSH M&E team worked tirelessly to ensure that the Electronic Medical Records System (EMRS) in the three pilot sites went live during the reporting period. The EMRS was successfully launched on March 1, 2016 and preliminary feedback from service providers thus far indicates that the EMRS platform is user friendly, has helped to streamline provider-patient interactions, and has had a positive impact on the overall patient care experience. Efforts are in place to enter the entire backlog of records to enable complete data generation from the platform for use in the next annual progress report (APR).

MSH actively participated in the 2016 World Tuberculosis Day celebration with the theme, *“Find TB, Treat TB and work together to eliminate tuberculosis”* held at the Rockview Hotel in Abuja on March 23, 2016 under the chairmanship of Honorable Minister of Health, Professor Isaac Adewole. In his remarks, he reiterated the commitment of the Government of Nigeria via the Ministry of Health (MoH) to improve the low TB detection rate, address the issue of multidrug resistant TB, and increase access to GenXpert technology nationwide. Across the 41 partner health facilities, MSH is working to improve TB diagnosis through ongoing partnerships with the state TB programs, the USAID-funded Challenge TB project in Niger state, and strengthening sputum sample transport systems to all supported sites with GenXpert capacity.

Overall performance against targets

A review of the overall project performance against targets shows that over 85% of the project indicators are doing well above 50% of the annual target at SAPR. For example, “Number of individuals who received testing and counseling services for HIV and received their test results (including PMTCT)” is at 77% of the annual target. There are two main factors contributing to the overshooting of the HTC target. First, some

state governments, in view of the ongoing transition process of responsibility for HIV services by PEPFAR, have procured and distributed HIV test kits to some of the project's supported facilities to ensure that provider initiated testing and counseling continues in these facilities. Secondly the SCMS program has continued to supply test kits to facilities based on their consumption reports rather than the set targets.

Both these factors are being addressed in the coming quarter. The recording of tests from the state supplied RTKs will be kept separate, while PEPFAR RTKs will continue to be used only in priority testing i.e. in TB clinics, Pediatric wards and for symptomatic clients. In addition, discussions are ongoing with SCMS and with USAID to ensure RTK supplies to facilities are capped according to set targets.

There are also a few indicators where project performance is below the expected level, such as "Number of infants born to HIV positive pregnant women who received an HIV test within 12 months" which is recording 45% achievement, and "within the < 2months age" category, the project is only at 19% of the annual target. The major contributing factors for this under achievement are the unbooked deliveries. These are mothers who have not been receiving ANC services at the facilities but come to deliver from there and do not return after delivery. That said, 64% of HIV exposed babies delivered by HIV positive mothers received an HIV test during the period. Measures to improve testing among exposed infants are being put in place. These include strengthening the mother baby follow up activities and scaling up the mentor mothers programs to more PMTCT sites.

2.1 Implementation Status

IR 1. Strengthened CSO and community structures for sustained HIV/AIDS and TB services

1.1 OVC services

The MSH Pro-ACT project is currently implementing OVC services in 18 sustained response LGAs (SRL) across the five focus states of Kebbi, Niger, Kwara, Zamfara and Kwara. In the quarter under review, Pro-ACT continued to prioritize and enhance efforts towards ensuring the sustainable delivery of OVC services by state government, CSOs, and community partners. In line with the USG COP15 directive that mandates the graduation of vulnerable households and their children and ensuring that OVC caregivers and children know their HIV status, MSH is working with all key partners to re-strategize and focus on implementing interventions that address household strengthening, meeting vulnerable children's most critical care needs, and working within the continuum of response to achieve an AIDS free generation. During COP15 planning, the USG country team set an initial target of graduating 30% of OVC caseloads out of the program by the end of FY2016, and the remaining 70% during FY2017. Complete transition is expected by September 30, 2017.

Reassessment and stratification of household for graduation

MSH is working towards the graduation of 30% of the enrolled 18,342 OVC caseload by September 30, 2016. To achieve this new USG/PEPFAR guidance, the fixed cost small grants of 9 out of the previous 11 CSO partners were renewed based on past performance, to provide quality services to households of OVC and to facilitate the graduation of 30% of the already enrolled households and their children. To enhance community ownership and sustainability, MSH in close collaboration with the CSO partners, is deploying a three-pronged approach for the implementation of the OVC graduation activities as outlined below:

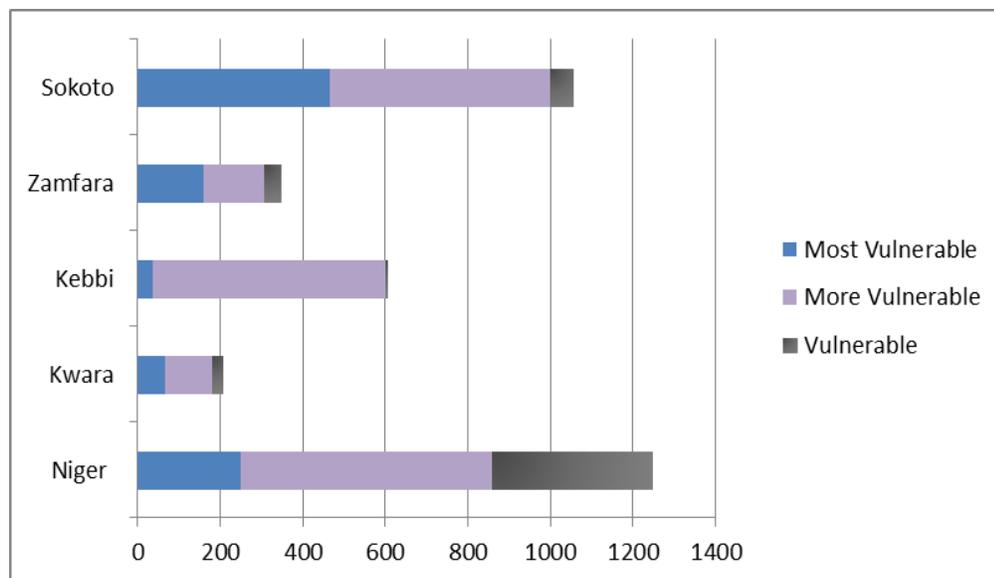
- Household caregiver must be an active member of a savings and loans association (SLA)
- Household must set up or acquire at least one income generating asset such as farmland, animals, equipment like grinding or milling machines, small businesses start-ups, etc.
- Household caregiver must be able to demonstrate the utilization of skills, such as ability to identify and utilize health services, nutrition, protection and psychosocial services within their community (*determined based on the application of the parenting map, which is a tool used to evaluate the application of skills the caregiver was trained on*)

As part of this initiative, a total of **3,464 households** of vulnerable children were reassessed across the five focus states during the quarter under review and categorized as Vulnerable (ready to grow), More Vulnerable (struggling to survive) and Most Vulnerable (state of destitution) to inform graduation efforts. The table below illustrates these categorizations by state.

S/N	Stratification/Categorization	# of Households Assessed					
		Niger	Kwara	Kebbi	Zamfara	Sokoto	Total
1	Vulnerable	390	28	6	41	56	521 (15%)
2	More Vulnerable	611	113	564	147	533	1,968 (57%)

3	Most Vulnerable	248	66	36	159	466	975 (28%)
4	Total	1,249	207	606	347	1,055	3,464

The stratification shows that 15% of the total 3,464 households assessed are vulnerable, 56.8% are more vulnerable, and 28.1% are most vulnerable. Further analysis by state reveals that Niger state has the highest percent (31%) of households that are vulnerable while Kebbi state has the least (1%).



The 9 partner CSOs are working to graduate the vulnerable households by the end of Q3, and it is projected that by Q3, 80% of the more vulnerable households will have been supported and strengthened to move to vulnerable household status and will graduate in time to meet the total target of households to be graduated in FY16.

Currently caregivers of 273 households, representing 8% of reassessed households in the project, have met the first criteria as members of savings and loans associations, which is the fulcrum Pro-ACT Household Economic Strengthening strategy. The partner CSOs are working with them to meet the second and third criteria of our graduation strategy (income generating asset and utilization of skills).

4,807 OVC and their caregivers were served during the quarter, 2,786 OVC and their caregivers know their HIV status, and of these, 64 tested HIV positive (22 male OVC, 6 Male Caregivers, 18 female OVC and 18 female caregivers). To strengthen two-way referral services between the CSOs and health facilities, and to ensure increased access to health care services – in particular, HIV services for sick OVCs – all partner CSOs have been formally introduced and linked with multidisciplinary service providers at partner comprehensive treatment sites. This strategy will address gaps encountered in the previous grant cycle in which two-way referral systems to the facility for HIV services and from the facility to community for OVC and other social protection services was weak.

During the reported quarter, MSH met with the Systems Transformed for Empowered Action and Enabling

Responses for Vulnerable Children and Families (STEER) project currently implemented by Save the Children in Sokoto. The key outcome of the meeting was the agreement by both projects to jointly support the Sokoto state government to develop and implement the state OVC plan of action.

Pro-ACT also participated in the meeting hosted by USAID for OVC service delivery partners where partners were encouraged to focus more on HIV infected and affected OVC and their households. The new definition for the OVC_Access indicator was also discussed.

Capacity transitioning to CSO and state government partners

During the quarter, a training workshop on Village Savings and Loan Association (VSLA) was conducted for both OVC and Positive Health Dignity and Prevention (PHDP) CSOs partners. 14 CSOs partners participated in the training that was held in two groups: one in Kwara State (February 29-March 4, 2016), and one in Niger State (March 14-18, 2016). A total of 18 CSO staff members from OVC CSO partners in the 5 project states received training. A key deliverable from the training was for the CSOs to reassess and modify where necessary their current VSLA methodology to ensure sustainability and results, while facilitating the formation of new VSLAs across all OVC program communities. In line with our sustainability efforts, 4 of the 5 OVC desk officers across the 5 project supported states participated in the VSLA training for CSO partners.

Pro-ACT further strengthened the capacity of the State Ministry of Women Affairs and Social Development to coordinate OVC programs through joint monitoring and mentoring of CSOs. Out of the 18 sustained response LGAs, 9 were supported to initiate Local Government Quality Improvement Teams (LGQIT) in the quarter under review. The LGQITs support and monitor the quality of services provided by the CSOs to the OVC and their caregivers.

A key challenge encountered during the quarter under review was the slow response and support by the state partners towards the development of comprehensive graduation and transition plan given the short timeframe to graduate 30% children through their households. Additionally, the stratification of households has revealed the enormous volume of work required for 30% of the currently enrolled children to be graduated through their household by September 2016. To address these challenges, MSH will reach out and work closely with the 4Children project which is funded by USAID to provide technical assistance (TA) to all OVC implementing partners. The project also plans to enhance its capacity by engaging a number of short term consultants who will be assigned to work closely and directly with each of the 9 CSOs.

Next quarter plans

- Continued provision of technical support on household economic strengthening, sustainability planning, case management and parenting support to state partners, grantee CSOs and communities to ensure successful graduation of households and OVC in Q3.
- Engage short term technical consultants to support and fast track the implementation of the comprehensive OVC graduation plan in all five focus states.

1.2 Community-based Positive Health Dignity and Prevention (PHDP) services

Working in collaboration with the 5 PHDP grantee CSOs, PHDP interventions within the quarter under review primarily focused on addressing retention challenges across the 41 supported sites in the five focus states of Zamfara, Kebbi, Sokoto, Kwara and Niger. To better appreciate the factors that contribute to poor retention rates from a client’s perspective, MSH conducted a mini-study in Q4 of FY15 in seven select sites. Overall, this study revealed that health facilities which hosted peer support group meetings with active membership had better retention rates compared to health facilities with inactive or no existing peer support groups. Specifically, the study identified membership of a support group as a great platform through which PLHIV are mobilized and facilitated to consistently adhere to their drugs and keep to their clinic appointments. A further analysis of the data revealed that 73% of defaulters and loss to follow-up (LTFU) clients who were actively tracked back were not members of any peer support group. Based on the study finding, MSH is working to strengthen or reactivate peer support group activities, and has prioritized 12 supported health facilities with client retention rates of not more than 65% for immediate intervention in Q2 as illustrated in the table below.

STATE	Health facility	FY 15 Retention rate
Niger	General Hospital Minna	51%
	General Hospital Mokwa	50%
Kwara	General Hospital Lafiji	54%
	Sobi Specialist Hospital	62%
Zamfara	General Hospital Kauran Namoda	56%
	Yerima Bakura Specialist hospital	65%
Kebbi	Sir Yahaya Specialist Hospital	46%
	General Hospital Argungu	56%
	General Hospital Koko	56%
Sokoto	Women and Children Welfare Clinic (WCWC)	15%
	Mariam Abacha Women Hospital	48%
	General Hospital Dogon Daji	55%

To achieve the objective of strengthening peer support group activities toward improving clients’ retention, MSH has deployed the following strategies in Q2, building on initial interventions commenced in Q1:

- Targeted membership drive in collaboration with NEPWHAN to ensure enrollment of new and old clients-contact information of support group coordinators were shared to all PLHIV during clinic days and other visits
- Linkage of referral coordinators in all supported health facilities to peer support group coordinators and community based service providers for improved referrals
- Registration of existing and newly initiated peer support groups with state chapters of NEPWHAN and other relevant government ministries and agencies
- Facilitation of the formation of Savings and Loans Association (SLA) as a strategy towards household economic strengthening and empowerment

These strategic interventions are beginning to yield early results as a total of two new PLHIV support groups were established in Zamfara and Kwara states and four inactive support groups were reactivated in

the same states. Across the supported health facilities in Kwara state, peer support group membership grew by 11% from 191 to 215 members as a direct result of the strategies deployed by MSH, in collaboration with the PHDP grantee CSOs.

Next quarter plans

- Finalize the registration of existing and newly initiated peer support groups with state chapters of NEPWHAN and other relevant government ministries and agencies
- Finalize the formation of Savings and Loans Association (SLA) in all exiting peer support groups.

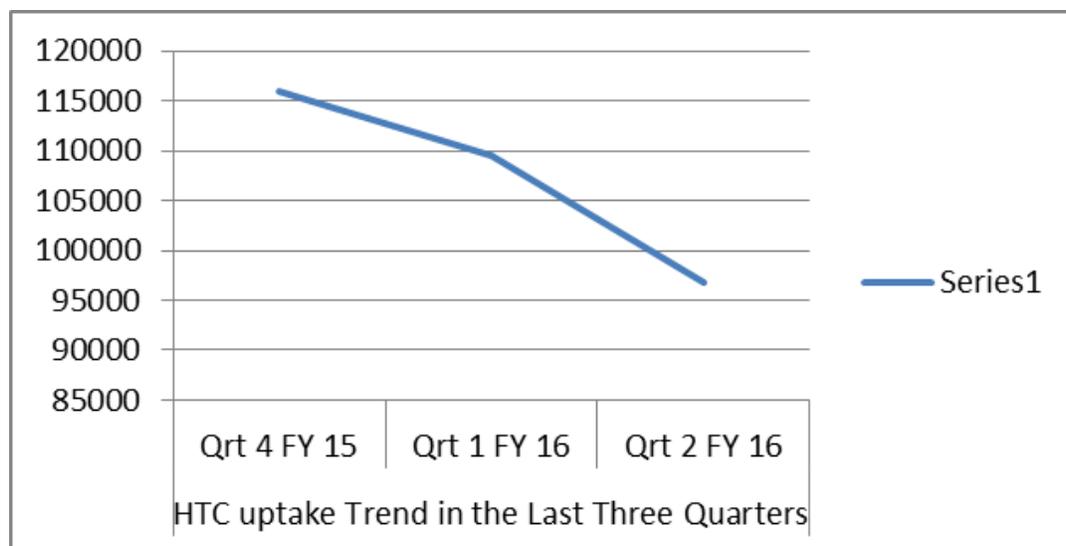
IR 2. Sustained access to quality integrated HIV/AIDS and TB services and products

2.1 HIV Testing and Counseling services

HTC services across the 41 MSH supported sites are currently being offered in line with the USG/PEPFAR guidance for IPs working in the sustained response LGAs which provides for targeted testing and passive enrollment. To ensure compliance with this strategic shift in the quarter under review, MSH worked to re-organize the delivery of HTC services in health facilities that received RTK donations. Clinicians were mentored to offer HTC services based on clinical symptomology which was approximated to not exceed about 5% of GOPD attendees, test 30% of new ANC clients, and ensure that all sick children and TB suspects are offered testing. Through negotiations with the hospital unit heads, a consensus was reached to utilize the RTKs donated by the state government to test 70% of the ANC clients and other clients who access testing services in the laboratory and other service delivery points not prioritized by PEPFAR.

In Q2, a total of **100,884** persons were counseled and tested, this is 9% less than the total number of persons counseled and tested in Q1 109,836 clients including children and pregnant women. With these numbers the project has now reached 77% of its annual target. A total of **6,908** children were counseled and tested in Q2, this is a reduction of 16.7% from the total number of children tested and counseled in Q1. This reduction may be attributed to a decline in the number of children that presented at the health facilities. There was a 19.8% increase in the number of TB suspects (**1,339**) tested and counseled in Q2, as against 1,078 TB suspects tested and counseled in Q1. Of the 100,884 clients tested, 3,539 were identified positive for a positivity rate of 3% in Q2 (which was the same rate registered in Q1).

A trend analysis of HTC service uptake data from Q4 FY15 through to Q2FY16, reveals a steady decline in the number of clients offered HIV tests across the 41 partner health facilities and this decline can be attributed to the ongoing effort to implement our HTC services using a targeted approach, which emphasizes limiting offering testing to only symptomatic clients, to patients in TB clinics and to those in pediatric wards. This is in line with USG and PEPFAR's sustained response mandate.



Challenges

Several challenges were encountered as state government partners and facility multidisciplinary teams are expressing concern about the impact of the new PEPFAR directive on HTC access particularly the directive to test only symptomatic new ANC bookings and those who actually request for the test (estimated to constitute 30% of all attendees). As a result, getting their buy-in on the implementation of the targeted testing approach and passive enrollment strategy has been challenging. Additionally state government partners who hitherto have been working closely with MSH towards the elimination of MTCT of HIV, and achieving universal access to HIV services are viewing these strategic shifts as a step backwards and are questioning if IPs such as MSH are working within the global principles of “do no harm”. To address the concerns of our facility teams and other challenges related to uptake of HTC services, MSH is continually advocating for budget releases for the procurement of health commodities such as RTKs, and has achieved some level of success with Kwara state government procuring and supplying 11 packs of determine (1,100 tests). Also the Zamfara state government procured and supplied 17 packs of determine (1,700 tests) and 5 packs of unigold (100 tests).

Next quarter plans

- MSH will continue to closely monitor HIV testing at all supported sites in order to ensure that we are achieving our targets based on our quarterly and annual projections
- MSH will continue to closely monitor RTK donations from the state government partners and will work to ensure that they are deployed in the non PEPFAR priority testing points
- Hold an internal consultative meeting with M&E, SCMS and lab teams to work out the reporting format for HTC service data capture based on PEPFAR priority testing points (TB DOTS, pediatrics, ANC (30%), clinical symptomatology (5%)) at partner health facilities

2.2 PMTCT

Over the second quarter of FY16, the gradual transition of the second group of 31 low yield MSH PMTCT sites (5-11 positive clients tested with a 12 month period) was completed by March 31, 2016, with further continued support to be provided by the various State Ministries of Health. This remains in keeping with

the directive from PEPFAR, with the first batch of 37 lower yield MSH PMTCT sites (0-4 positive clients tested with a 12 month period) earlier transitioned by September 30, 2015 (see table below). The formation of various State Transition Committees headed by the permanent Secretary MoH, and also the early engagement of key stakeholders/state actors – including SACA, Representatives of Ministry of Budget and Planning, Representatives of Civil Society Organizations – remained key to the success of this transition.

Table 1. Breakdown of Transitioned PMTCT sites by states

	Niger	Kwara	Sokoto	Kebbi	Zamfara	Total PMTCT site
Total PMTCT sites supported in FY 15	114	27	10	27	20	198
Total PMTCT sites transitioned by September 30 2015 (0-4 positives)	23	1	0	11	2	37
<hr/>						
Total PMTCT sites supported FY 16 (Oct-Mar 31)	91	26	10	16	18	161
Total PMTCT sites transitioned Mar 31 (5-11 positives)	23	3	0	2	3	31
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Total MSH PMTCT sites supported after March 31	68	23	10	14	15	130

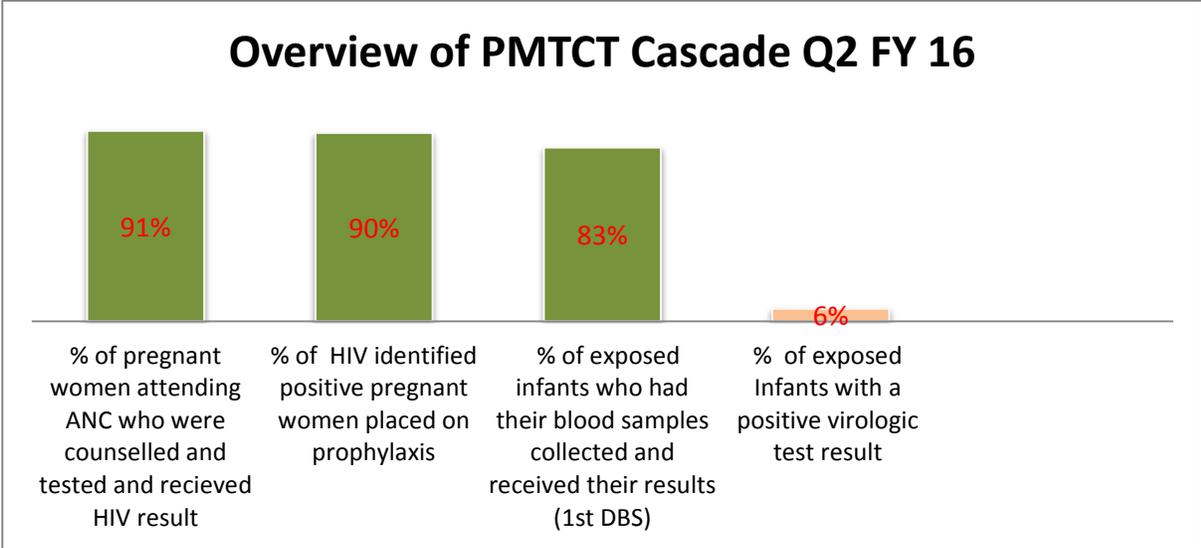
Also with the second quarter of FY16, MSH continued to provide qualitative PMTCT in all supported facilities. A review of key Q2 achievements in all 161 supported PMTCT sites revealed that 91% (41,659/45,966) of all new women attending ANC were provided with HIV counseling and testing (HCT) within the quarter. This remains quite comparable to the achievement of Q1 (93%), however a review of the cumulative achievement for the total number of pregnant women with known HIV status for FY16 of 92,606, shows that we attained 151% of our set SAPR target (61,217). This overachievement is reflective of the continued support of provider initiated testing and counseling (PITC) for pregnant women at ANC through the uninterrupted supply of PEPFAR supported test kits in MSH facilities. Discussions are ongoing with SCMS to cap the supply of RTKs to facilities and to emphasize to facilities to limit PEPFAR supplied RTKs for testing only symptomatic clients and those that request for the service.

Over the quarter, 90% (559/621) of all identified HIV + pregnant women were placed on ARV prophylaxis for PMTCT. Although this represents a slight decrease from Q1 (603/629 or 95 %), our total cumulative achievement of 1,161 for FY16 remains at 78% of our set annual progress report target of 1,485.

Our performance in early infant diagnosis also revealed that 814 exposed infants born to HIV positive pregnant women received an HIV test within 12 months. This also represents 54% of our APR target of 1,485.

An overview of the PMTCT Cascade (see table below) revealed that despite reaching 90% of HIV positive pregnant women with ARV prophylaxis, we still have an exposed infant seropositivity rate of 5.7%. Though this is below the national rate of 7%, it remains above our e-MTCT target of 1%. The high rate of 20% (81/413) of unbooked HIV positive pregnant women delivering in our facilities that do not receive ARVs during ANC and exposed infants referred for testing contributed significantly to this.

Also within the quarter, 6 of our trained MSH Mentor Mothers facilitated our PMTCT training for health care workers in Niger, Kebbi, Kwara and Zamfara states. This was used as an opportunity to share their experiences and inspiring stories in improving patient retention through the PMTCT cascade within their



health facilities and for possible scale-up in specific high yield PMTCT Sites. These volunteer mentor mothers remain key to the PMTCT program, with each mentor mother providing support to a minimum of 30 HIV positive pregnant women.

2.3 Pediatric HIV Care and Treatment Services

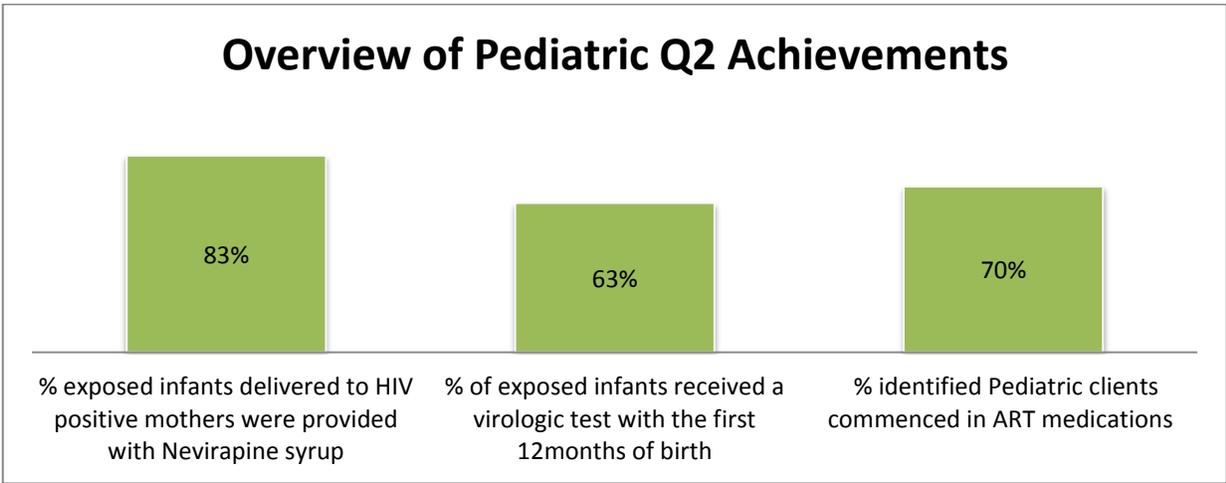
The continued improvement in the quality of services remained the main thrust of the pediatric HIV activities carried out in the last quarter. In ensuring qualitative pediatric service, a training on the care and management of HIV exposed and infected infants and children in all comprehensive sites was conducted using a training needs assessment between February 22-26, 2016. A total of 91 health care workers (HCWs) made up of doctors, nurses, pharmacists and CHEWs were trained in Pediatric HIV care across project states with a follow-up training impact assessment scheduled within the next quarter.

A review of key activities and achievements over the reporting period revealed that 83% (402/486) of all exposed infants delivered to HIV positive mothers were provided with Nevirapine syrup as complete course of PMTCT prophylaxis for 6 weeks. This gap further reflects the significant number of exposed babies (208) constituting 43% delivered outside of the facilities and presenting after 72 hours to the

facilities. Also within the review period 73% (305/486) of exposed infants received a virologic test with the first 12 months of birth. To further ensure all exposed infants are provided with virologic test at 6 weeks of birth and above, an exposed infant care card is filled at birth and used for follow-up tracking of the mother-baby pair. Mentor mother volunteers are also currently supported in Suleja in Niger state and will be introduced in other states to improve retention of the mother baby pair.

In line with 90:90:90 global goals and in keeping with USAID directive, Provider Initiated Counseling and Testing (PITC) for all pediatric clients continued in all MSH facilities targeting pediatric clients in all patient clinic/ward, children emergency clinic, TB and nutrition units .

A total of 6908 children, aged <1-14 years were tested in Q2 with an HIV seropositivity rate of 3% (211/6908). This remains similar to our findings in Q1(2.9%) and consistent with the national HIV prevalence of 3.1%. Further analysis also revealed that 70% (148/211) of identified pediatric clients were commenced on ART medications in line with the 90:90:90 initiative above.



The MSH NIPOST SPEEiD model continued to provide a veritable platform for the transportation of Dried Blood Spot (DBS) for early infant diagnosis within the quarter with results of 581 analyzed samples received within quarter. The SPEEiD model has been adopted by the FMOH for possible nationwide scale-up. The main challenges over the period were the delays with sample analysis at the PCR laboratory due to reagent shortage in January and a break in services over the festive holidays resulting in an increased sample backlog.

Adolescents HIV care and treatment services

Although the DREAMS initiative, which has the goal to help girls develop into Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe women is not being implemented in Nigeria, MSH is proactively analyzing data of new HIV infections that occurred among adolescents, particularly girls and young women, enrolled under the Pro-ACT project. A review of our Q2 program data revealed that 6.2% of patients fall within the adolescent age group, with seropositivity rate of 3% (121/4322). Although this appears similar to the national HIV prevalence, the peculiarity of this unique group puts them at a higher risk of HIV transmission. These adolescents and in particular the females are at a sensitive period of transition into adulthood with its many physical, psychosocial, cultural and economic dynamics. Managing

their insight and understanding of the disease remains challenging for these adolescents, with a lower retention rate in care and only about 50% of HIV positive identified adolescents enrolled into care. Horizontal transmission also appears to be a new challenge as 179 adolescents (10-19 years) were identified as HIV positive over the last quarter in all supported sites. These provide further evidence towards the need for targeted MSH interventions focused on adolescent HIV care over the next quarter; including focused adolescent adherence counseling, adolescent centered support groups/clubs and adolescent focused client tracking.

Next quarter plans

- Collaborate with the OVC/community team to initiate a support group for young women and adolescent girls to cater for the needs of adolescents in transition, who may have been infected through horizontal and vertical transmission
- Conduct a facility specific pediatric client audit FY 16 (October-March) to identify gaps within our program that are facility specific.
- Collaborate with the facility teams to improve the retention of HIV exposed/positive infants within the continuum of HIV care
- Collaborate with the facility teams to improve the nutritional assessment/therapy among malnourished pediatric HIV clients, with focus on under 5's

2.4 Adult HIV Care and Treatment services

In the quarter under review, Pro-ACT continued to implement sustainable HIV/AIDS interventions at the facility level in line with PEPFAR strategic treatment shift across the sustained response LGAs. Building on Q1 quality gap improvement efforts, key areas of focus in Q2 were addressing retention gaps in all 41 partner health facilities based on FY15 APR performance which shows an aggregate retention rate of 62%. Addressing this specific challenge necessitated a multi-pronged approach with the formation of a country office retention team, state retention committee, and identification of facility retention champions in each supported site. Specific strategies deployed include:

- Accelerated physical tracking of defaulters augmented by the use of mobile technology, and identification and engagement of community volunteers (trackers and patient escorts).
- Mentoring of site clinicians and support staff to improve service data documentation and address program gaps.
- Identification and designation of highly motivated facility staff as Retention Champions.
- ART data review, update and triangulation of clients reported on the ART register, and those reported using the pharmacy daily worksheet domiciled at the pharmacy unit.
- Ongoing linkage of newly enrolled and existing HIV positive clients to peer support groups as well as initiation of neighborhood clusters of HIV positive clients living within the same locality to enhance tracking outcomes.
- Optimization of the use of MSH customized tools (retention calendar and tracer cards) to improve retention and defaulter tracking outcomes.

By the end of the quarter under review, some notable impact of these strategies has been observed among which are:

- Reduced patient waiting time and improvement in the overall clinic experience as a direct result of streamlined clinic flow and a task sharing initiative. Currently, in select facilities, stable patients do not wait in the long queues to be seen by clinicians. Nurses have now been mentored to triage, fill out care cards and prescribe routine ART thereby reducing the daily patient work load of onsite physicians.
- Also 85% of HIV positive clients who were eligible to commence ART (CD4 count < 500) were initiated on life saving ARVs within Q2.
- Discussions were initiated with facilities to start providing 3 months drugs supply to stable patients to reduce the frequency of their visits to facilities for drug pickup.
- 530 defaulters were actively tracked back and recommenced on ART after going through a structured and customized ARV treatment re-education.
- Four viable neighborhood clusters of HIV positive clients living in the same locality were successfully initiated for clients who access services at General Hospital (GH) Nasko, General Hospital (GH) Tunga Magaji and General Hospital (GH) New Bussa, which are all situated in Niger state.
- State ART patient retention rates have improved in 4 of the 5 states over the last two quarters as seen below. In Kebbi state, however the retention has slightly deteriorated and the project will intensify efforts in the state, including addressing the staffing challenges the MSH state team is currently facing, to address this issue.

	% of adults and children who are still alive and on treatment at 12 months after initiating ART(Numerator)		
	APR – Sept 2015	SAPR – March 2016	Percentage change
Sokoto	56%	65%	9%
Kwara	69%	74%	5%
Niger	62%	65%	3%
Zamfara	66%	68%	2%
Kebbi	57%	54%	-3%

Q2 ART performance

A review of key achievements in this quarter across the 41 supported ART sites revealed that 1,833 new patients (Males = 670; Females = 1,160) were enrolled into care. 29,739 (Males = 9,361; Females = 20,378) patients are currently on ART which represents 120% of the annual program target (Niger: 14,584; Kwara: 4,951; Zamfara: 1,606; Sokoto: 4,656; and Kebbi: 3,436). It is worth noting here that the annual target for this indicator (**24,922 patients Current on ART**) was set at a level lower than the actual number of patients we had on ART and the beginning of FY 16.

Further validation will be done after the RADET exercise, which is currently ongoing.

Pro-ACT Q2 ART performance

MSH TOTAL

Indicators	Annual target	Q1 Target	Q1 achieved	Q2 Target	Q2 achieved	Q2 achieved %	SAPR 16 (Q1 + Q2) achieved	SAPR 16 (Q1 + Q2) % achieved
Current on ART	24,992	24,992	29,134	24,992	29,739	119%	29,739	119%
Newly enrolled (ART)	4,910	1,228	1,864	1,228	1,941	158 %	3,805	77 %

Challenges

In an effort to ensure ownership and sustainability of HIV care and treatment services in the five focus states of Niger, Kebbi, Zamfara, Sokoto and Kwara, MSH initiated the Care and Treatment Technical Working Group (TWG) in 2014. The TWG is a holistic strategy to drive the provision of TA to the 41 partner health facilities. However, over one year post inauguration, most of the TWGs have remained inactive due to a paucity of state funding to implement and achieve the TWG’s activities, as detailed in the work plan, as well as the overall goals and objectives of the group. Additionally, in Q2, inadequate and poorly motivated human resources for health (HRH) capacity continues to pose a challenge, as most HCWs still complain of high work load and burn out. To address these challenges MSH is working closely with the state ministries of health (SMoH) to reevaluate the status of the TWG and come up with a clear plan of action that will ensure that the TWGs play the role they were designed to perform. Additionally, MSH continues advocating for funding from the state to fully jump start their activities. To address the challenge of poor motivation among frontline healthcare workers, MSH will continue to profile HRH issues at the state and LGA level, and will collaborate with other international partners working in the state to advocate for the recruitment and deployment of skilled healthcare workers to supported sites.

Next quarter plans

- Project wide efforts to address quality gaps, particularly poor retention rates, will be sustained through ongoing collaboration with state government partners.
- Service delivery approaches, aimed at improving services by addressing clients’ specific needs, providers’ constraints and lowering barriers to care, will also be sustained.
- Approaches tailored to increase efficiency by reducing congestion at the facility and optimizing staff workload while improving patients’ health outcomes (initiation, adherence, retention, and viral suppression), will be scaled up to additional facilities in Q3.

2.5 Supply Chain Management Systems (SCMS)

The SCMS activities carried out during the quarter were geared towards ensuring sustained access to quality integrated HIV/AIDS and TB services and products, adequate availability of health commodities at the service delivery points, optimization of viral load (VL) test at the UDUTH molecular lab, client retention, utilization of RTKs at PEPFAR prioritized testing points, ART regimen analysis, and data quality assurance (DQA). These activities are in line with COP 15 directives and are also aligned towards achieving the UNAIDS 90:90:90 goals.

Pharmaceutical Care

In order to reduce complexity and accelerate the roll out of treatment, Federal Ministry of Health (FMOH) began streamlining of first line adult drug regimen from about 35 to 11 in 2011 all the way down to 3 in 2013, in line with WHO guidelines. The 2013 quantification exercise followed carefully through quantification assumptions, drug procurement and supply chain management plans. The goal was that the choice of regimen would ensure cost reduction, improve access to HIV drugs, reduce toxicity, reduce wastages, simplify ease of storage, reduce pill burden, as well as reduce HIV transmission. These efforts were followed up with a directive from the FMOH on regimen streamlining for clients on antiretroviral therapy (ART) across the country, through a memo disseminated by the National AIDS/STDs Control Programme (NASCP) in January 2014.

MSH has continued to work closely with facility teams on the implementation of the FMOH recommendations through ongoing bi-monthly regimen analysis of clients on ART. In line with this, a regimen analysis was conducted which revealed that 89.44 % of adult clients on ART are on Tenofovir (TDF) based backbone, while 9 % are on Zidovudine based backbone, while only .004% are on Abacavir backbone. This result clearly indicates that MSH is in line with the directive to place 90% of all newly initiated ART clients on TDF backbone. This result was achieved through capacity building, sustained supervision and hands-on mentoring of facility teams.

Triangulation of ART patient data with pharmacy records

At the end of Q1 FY16 program data of adults currently on ART, reported by the records unit/M&E, was 29,739, while the pharmacy unit reported 30,299 on ART, with a difference of 560 (2% variance). Based on this finding, and in order to fully understand patterns of access to ART services at the 41 supported sites, we reviewed and collated data on all individual clients accessing ARVs in each health facility, as documented by the records unit. This data was then reconciled and verified by triangulating with the pharmacy records of ARV drug pick-ups and dispensing. This exercise revealed that in Q2 a total of 30,742 clients on ART was reported by the pharmacy unit, while data from the records unit/M&E indicated that 29,739 were currently on ART, with a discrepancy of 1,003 (3% variance). Further inquiry revealed that these variations are mainly due to incomplete documentation, such as ART status registers not being updated at the facilities, the issue of VIP clients, LTFU, and tracking challenges, as well as patients who self-transfer out without any notification. These challenges have continued to impact the individual facility retention rates. To address these, MSH will continue to analyze and triangulate data from the records and pharmacy units to inform program improvements.

Health commodity management

HTC services across the 41 MSH supported sites are delivered in line with the USG/PEPFAR guidance for IPs working in the sustained response LGAs which provides only for targeted testing, passive enrollment and discontinuation of all demand generation activities. The JSI led supply chain project, SCMS, has continued to supply RTKs and other laboratory commodities to all PEPFAR supported sites. This is done using the “pull principle”, even though IPs working in the sustained response LGAs have been mandated to prioritize and scale back on provider initiated HIV testing. Test kit utilization reporting cycle for commodity management is bi-monthly, and in Q2 MSH has continued to analyze test kit utilization trends across the supported states. Between November and December 2015, a total of 111,991 determine kits were utilized. This

included 93,291 (83.3%) supplied by PEPFAR from JSI/SCMS, and 18,700 (16.7%) procured and supplied by three state governments partners of Kwara, Niger, and Zamfara in direct response to the PEPFAR's directive on HIV testing in order to bridge any testing gap. A deeper analysis of the bi-monthly supply data of RTKs provided by JSI/SCMS in Niger State revealed an oversupply of RTKs as against facility reported utilization which was not in line with the pull principles of commodity supply chain management. For the Sept-Oct 2015 re-supplies a total of 41,000 determine test kits were supplied on a request of 37,700 kits, giving an excess of 3,700 kits. Additionally, for Nov-Dec 2015 re-supplies, facilities requested a total of 31,000 determine kits, but JSI/SCMS supplied 34,700 kits, an oversupply of 3,700 kits. The cumulative RTK supply in excess of request over a period of 4 months was 7,400 kits. These excess supplies have contributed to the overachievement of the HTC target in Q1 (41%) against the expected (25%). The project has held discussions with SCMS on this and proposals have been made for capping future RTK supplies to facilities in accordance with their set HIV test targets.

Challenges

Clients on Non-Streamlined Regimen at UDUTH, Sokoto

MSH has made significant progress in transitioning ART clients to the preferred TDF based backbone across all sites. In UDUTH a detailed ART regimen analysis was conducted between March and Sept 2015, and we observed a reduction in the number of clients on non-streamlined regimen at end of April from 126 to 73 clients in June and a further reduction to 32 clients at the end of September 2015. These 32 clients were reviewed as not suitable for placement on streamlined regimen because of reported cases of severe adverse effects on previous regimen, and have been transitioned from one regimen to the other before finally being left on their current regimen. A detailed analysis indicates the pattern of adverse events: Anemia (55.6%), Hepatitis (22.2%), generalized rashes (11.1%), and darkening of skin and nails (11.1%) while on AZT or ABC plus 3TC/NVP combination. Similarly, patients experienced at least one of the following while on TDF or ABC+ 3TC/EFV combination: intense dizziness (44.4%), and/or hallucination and insomnia (33.3%). **22.2% of these clients had contra-indications to the use of this combination because of background history of psychosis.** These 32 clients are currently on non-streamlined regimen as a result of the adverse reactions/side effects and contra-indications and they will need to be supported. MSH is exploring several options with the FMOH, National Agency for the Control of AIDS (NACA), and UDUTH to see how they can be supported to get continued access to the non-streamlined regimens.

Next quarter plans

- Monitor, in collaboration with the M&E and Lab team, the utilization of RTKS at PEPFAR prioritized testing points (TB dots, pediatrics, clinical symptomatology, 5% GOPD, 30% ANC). Data on total number of clients that accessed services in Q3 will be collated and disaggregated by the PEPFAR prioritized points.
- Conduct an SCMS focused training needs assessment across all the 41 partner health facilities and then plan for a supply chain management training that incorporates sessions on adherence counseling.

2.6 TB/HIV

MSH Pro-ACT TB/HIV collaborative activities are anchored on World Health Organization (WHO) three I's strategy:

- Intensified case-finding (ICF);
- Isoniazid preventive therapy (IPT); and
- Infection control (IC).

During the quarter under review, MSH actively participated in the 2016 World Tuberculosis Day celebration with the theme "Find TB, Treat TB and working together to eliminate tuberculosis" in Abuja and supported the various state partners to plan for the World TB activities. In this quarter, MSH collaborated with the USAID funded Challenge TB project implemented by KNCV in Niger state to enhance the state's TB response. As part of this collaboration MSH facilitated a meeting with the state TB program, KNCV and Riders for Health for the initiation of a sputum sample transport that will link 66 health facilities to 7 MSH supported labs with GeneXpert capacity.



Minister of Health unveiling the representative of the wife of the president as TB Champion

In Q2, the project screened 3,853 PLHIV using the WHO symptom checklist, identified 225 presumptive TB cases, with 100 co-infected patients commencing TB treatment. The TB screening rate remains similar to Q1 achievements however, presumptive TB cases were in excess of 44 in Q1 in comparison to Q2. Co-epidemic cases for Q2 exceeded Q1 cases by 19. Broad strategies deployed during the quarter for optimal TB screening focused emphasis on multiple service point screening, continued use of TB SOPs, review of TB service and data flow in select facilities. Furthermore, with continued strengthening of GeneXpert referral sample network, 794 samples were evaluated using the GeneXpert technology with 233 diagnosed as co-epidemic cases (TB/HIV), 34 patients were identified as TB cases while the remaining 5 patients were found to have Rifampicin resistant TB. Additionally, emphasis on infection prevention and control interventions in supported facilities ensured 1,233 PLHIV accessed Isoniazid Preventive Therapy (IPT) while 263 patients completed 6 months course therapy of IPT by the end of Q2.

Challenges

In Q2, five facilities experienced lingering GeneXpert machine down time which impacted greatly the uptake of services and was a key factor identified as a delay in obtaining a service contract with Cepheid. Currently 8 GeneXpert platforms are out of warranty and MSH is working closely with KNCV and Cepheid to finalize the warranty for these machines. Additionally, poor linkages and poor understanding of TB service flow at some partner health facilities continues to account for about 42% of missed opportunities.

Next quarter plans

- Evaluate TB service delivery and data flow at select health facilities to address the gap of missed

- opportunities.
- Finalize service contracts for all GenXpert platforms and ensure repair of malfunctioning platforms.
- Ongoing support and mentoring of facility teams on the delivery of collaborative TB/HIV services.

2.7 Facility-based Positive Health Dignity and Prevention (PHDP) services

MSH Pro-ACT facility based PHDP intervention is aimed at providing ongoing patient education and psychosocial support from time of enrollment to commencement of ARVs, which is critical for the inherent understanding of PLHIV on the importance of adhering to their ARV medications and clinic appointments. With the evidence demonstrated by several studies that the proportion of missed ARV doses correlates directly with risk of virologic failure, PLHIV who access services at MSH supported health facilities are also being counseled and educated on the critical importance of good adherence, which is key to achieving viral suppression, during one-on-one adherence counseling sessions. Other topics covered during these sessions include: benefits of medication adherence, side effects of ARVs, stigma, and disclosure. MSH trained adherence counselors provide this on-site service to clients on a one-on-one basis, or in groups at designated hospital units with audio-visual privacy.

Within the quarter under review, a total of 14,672 PLHIV received facility based PHDP services from across the 41 supported health facilities in the five focus states of Niger, Kwara, Kebbi, Sokoto and Zamfara. A further breakdown indicates that 6,273 males and 8,399 females benefitted from PHDP services. This achievement represents a 57% improvement from Q1 and can be attributed to the successful conduct of the ART and PHDP training workshop organized in Q1 in which 129 health care workers and adherence counselors participated in. In Q3, MSH will collaborate with the state chapters of NEWPHAN to initiate adherence clubs and also strengthen existing community adherence support groups in order to build on the successes of Q1 and Q2.

2.8 Continuous Quality Improvement (CQI) activities

The MSH Pro-ACT quality improvement (QI) strategy is comprehensive, multi-pronged and involves the application of the *Site Improvement through Monitoring Systems (SIMS) tool*, *NigeriaQual program reporting*, use of the mentorship logbook, support of facility Quality Improvement (QI) teams, and the implementation of facility-specific QI projects. In FY16 Q2, the quality improvement initiatives mainly focused on strengthening the capacity of supported facilities to address quality gaps such as poor client retention rates.

Domain subsection	Second Visit with Improvement Plan in Place (Process Evaluation)			Third Visit (Impact Evaluation) Measuring Progress of Adopted Improvement Plan		
	Color Code	Comments	Date	Color Code	Comments	Date
PEDIATRIC ART						
Pediatric Cotrimoxazole		CTX documentation remained at 60% in review carried out in June 2015.	Aug-15		An achievement of 90% was noted	Jan-16

Domain subsection	Second Visit with Improvement Plan in Place (Process Evaluation)			Third Visit (Impact Evaluation) Measuring Progress of Adopted Improvement Plan		
	Color Code	Comments	Date	Color Code	Comments	Date
Pediatric TB screening		An improvement to 70% was recorded in June 2015 review.	Jun-15		An achievement of 80% was noted	Jan-16
TB/HIV						
TB Diagnostic evaluation cascade		Line register is available and is in use.	Apr-15		An achievement of 100% was recorded	Jan-16
Isoniazid preventive therapy (IPT)		SOPs have been made available in DOTS unit.	Apr-15		An achievement of 100% was recorded	Jan-16
Site Management: Performance Management						
Supportive supervision		MSH mentorship logbook in use to document clinical supportive visits.	Apr-15		MSH mentorship logbook in use to document clinical supportive visits.	Jan-16
Site Management: QM/QI						
Assessment and Utilization of Performance Data in QI Activities		QI Project on Adherence assessment & documentation being implemented using a baseline of 47.47% obtained from NigeriaQual data (July – December 2014).	Aug-15		QI Project on Adherence Assessment & Documentation achieved 91.9% (NigeriaQual July - December 2015)	Jan-16

Care & Support						
Patient Tracking (Pre ART patients)		Reviewed the list of Pre-ART patients LTFU and tracked them	Aug-15		LTFUs are being tracked back to care and registers duly updated	Jan-16
Facility linkage to community Care and support services		Developed referral directory for facilities and communities within the state for support services and proper coordination			Developed referral directory for facilities and communities within the state for support services and proper coordination	Jan-16

Stigma and discrimination		National policy for HIV/AIDS made available in facility	Aug-15		National policy for HIV/AIDS made available in facility	Jan-16
Patient Rights		National policy for HIV/AIDS made available in facility				National policy for HIV/AIDS made available in facility

Implementation of facility specific continuous quality improvement (CQI) projects on retention:

- Facility QI projects were implemented across 37 CCT sites and were aimed primarily at improving retention and addressing other programmatic gaps identified from NigeriaQual performance measurement.
- Facility specific retention strategies were developed which included designation of retention champions, mentoring of facility teams on the use of retention calendar, streamlining intra-facility escort services, documentation of VIP patients, daily updating of ART register and monthly triangulation with pharmacy status registers. Each facility has been mandated to review retention performance at every monthly QI meeting with priority reporting and analysis for cohort whose patients one year is ending.
- Leveraging on QI meetings, 12 facilities with retention rates less than 60% have set timelines and milestones of achieving 20-30% improvement in the facility retention rate by September 2016.

Assessment of quality of healthcare service delivery using the SIMS Tool

In FY16 Q2, SIMS tool was applied as the standard tool for assessing the quality of healthcare services provided to PLHIV in MSH-supported facilities. The SIMS Tool was applied across 17 sites in Q2 (Kwara 8, Sokoto 7, and Niger 2). Common programmatic issues noted included prolonged turnaround time for EID, poor CD4 documentation, patient tracking and facility linkages to community care & support services.

In March 2016, USAID conducted an external audit on quality of services provided to PLHIV across 5 facilities (3 comprehensive sites and 2 primary health care centers) in Kebbi state. Below are some of the findings from the quality of service audit. Following the SIMS assessment, remediation plans were developed and are currently being implemented to address noted gaps.

S/No.	Facility Name	% of Core Essential Elements Surpassing Expectations
1	GH Yauri	91.3%
2	GH Koko	86.4%
3	GH Maiyama	77.8%
4	GH Jega	74%
5	PHC Bagudo	53%

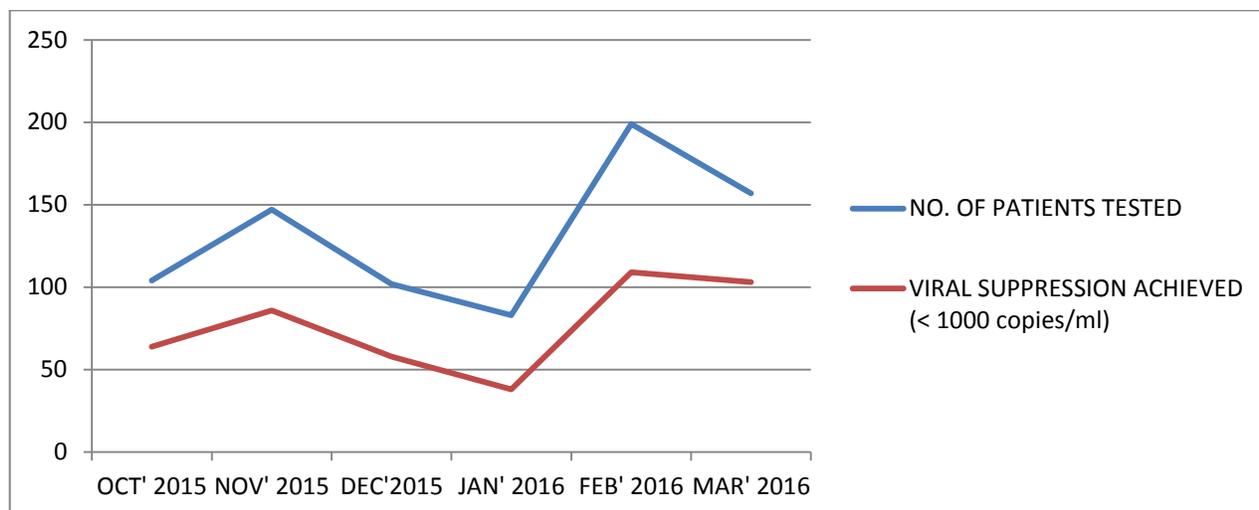
2.9 Laboratory systems strengthening activities

Pro-ACT continued its effort in ensuring sustained access to HIV care and treatment services and in strengthening various systems for the delivery of sustainable laboratory services at the 41 partner health facilities. A key thrust of the project's lab activity in Q2 was working collaboratively with facility multidisciplinary teams at UDUTH to optimize viral load testing at molecular lab. In response to ongoing efforts to strengthen laboratory capacities through accreditation of laboratories, MSH Pro-ACT has continued to build on the successive collaborative effort of the program over the past years. Additionally, Pro-ACT has had various state level engagements to sensitize relevant government departments and laboratory focal persons at the State Ministry of Health (SMoH) on the need to sustain the workings of the lab TWG as a coordinating mechanism for monitoring performance of laboratory networks. This is in line with MSH's approach towards supporting the accreditation of laboratories in the five focus states.

Analysis of viral load (VL) testing uptake at Usmanu Danfodiyo University Teaching Hospital (UDUTH)

HIV viral load is considered to be the best marker for clinical decision making after initiation of ART. In line with the current UNAIDS 90:90:90 goal, the PEPFAR support for the scale-up of viral load testing as recommended by WHO 2013 guidelines is aimed at demonstrating epidemic control in populations. To achieve this, Pro-ACT advocated for the optimization of viral load testing in Usmanu Danfodiyo University Teaching Hospital (UDUTH), where MSH supports the PCR laboratory and set a target of 1,512 viral load tests to be performed per quarter. In Q1, 353 VL tests were performed while in Q2, a total of 439 VL tests were performed. Given the quarterly target of 1,512 tests, this represents a 23.35% and 29.03% uptake of VL services respectively. Despite a 6% increase by Q2, this falls short of the intended target. Part of the reason for the low performance is the low demand for the VL tests by the clinicians. The shift of emphasis from using CD 4 test to using viral load test to monitor patients on treatment has not been communicated very well and is not consistently understood by health care workers. As a strategy for increasing uptake of VL test services, the project will organize; starting next quarter, a series of VL focused CMEs for health workers from UDUTH and other facilities in Sokoto state. Linkages between UDUTH and other facilities that refer VL samples to the PCR lab will also be further strengthened .

A further analysis of the lab service data revealed that 250 patients achieved viral suppression using the threshold of 1000 copies/ml of blood. 178 patients had VL levels above this threshold. 11 samples were either invalid, yielded no results or needed repeat assays.



In order to determine the level of viral load testing uptake in Q2, a cohort of clients initiated on treatment in September 2015 who will be eligible for a VL test in six months (March 2016) was assessed. Data abstraction showed that of this cohort of 35 patients, none had a request for viral load testing. This highlighted the importance of laboratory and clinical team interphase in identifying and proactively making requests for VL testing for clients initiated on treatment at six months in line with the national guidelines.

Uptake of GeneXpert technology

11 out of 41 MSH partner sites currently have GeneXpert capacity and the project has continued to strengthen clinical and laboratory diagnostic interface following sustained sensitization on the use of GeneXpert technology as the preferred and first line diagnostic tool for TB. This is in addition to also working to improve sputum sample referral and linkages across the network of laboratories with GeneXpert capacity. As a direct result, there was a marginal increase in the total number of sputum acid-fast bacilli (AFB) screening from 2083 in Q1 to 2420 in Q2. To optimize GeneXpert technology, MSH prioritized high volume sites such as UDUTH, which also receives sputum referrals from three other comprehensive sites located within Sokoto metropolis. By the end of Q2, a total of 312 patients (Males: 189; Females: 123) were screened cumulatively (Q1 and Q2) in UDUTH. 98 of these clients were HIV positive (31.41%). 76 of these patients were identified as mycobacterium tuberculosis (MTB) cases, of which Rifampicin sensitive strains were 63 (82.89%) while Rifampicin resistant strains were 11 (14.47%).

Strengthening Laboratory Management Towards Accreditation (SLMTA)

In FY15 UDUTH, one of MSH supported sites, was enrolled into the Strengthening Laboratory Management Towards Accreditation (SLMTA) Cohort 3 program with the objective of preparing the facility to attain WHO accreditation. A baseline gap assessment was conducted and the facility scored rather poorly against most assessment criteria. In the quarter under review, a second gap assessment was conducted which showed encouraging improvements from the baseline position. Despite these improvements, a lot still needs to be done as the site is yet to attain the ONE STAR status. MSH will continue to support the facility and with small test of change (STOC) projects already identified for the facility, the site should be able to plug the identified gaps that will take it to the next level up the ladder of accreditation.

Accreditation readiness baseline and follow up assessment scores of UDUTH Laboratory

AUDIT SCORE SHEET			
SECTIONS	TOTAL POINTS	BASELINE AUDIT	FIRST FOLLOW UP AUDIT
Section 1: Documents & Records	28	2	12
Section 2: Management Reviews	14	2	0
Section 3: Organization & Personnel	22	6	11
Section 4: Client Management & Customer Service	10	1	4
Section 5: Equipment	35	11	25
Section 6: Evaluation and Audits	15	2	5
Section 7: Purchasing & Inventory	24	9	19
Section 8: Process Control	32	10	25
Section 9: Information Management	21	6	13
Section 10: Identification of Non Conformities, Corrective and Preventive Actions	19	0	0
Section 11: Occurrence/Incident Management & Process Improvement	12	0	4
Section 12: Facilities and Biosafety	43	15	21
TOTAL SCORE	275	64	139

Challenges

Advocating for and mobilizing funding resources from state government partners to sustain services transitioned by PEPFAR such as chemistry and hematology test has been challenging. To mitigate the impact this may have on patient care and access to laboratory services, MSH Pro-ACT project is strengthening the existing laboratory revolving fund models at partner health facilities as a key strategy towards ensuring alternative financing mechanism which will ultimately sustain PEPFAR-initiated laboratory programs. Currently about 8 out of the 11 GenXpert platforms are out of warranty and MSH is working closely with KNCV and Cepheid to finalize the warranty for these machines.

During the quarter under review, there was yet another recurrence of the supply of CD4 reagents with highly compromised manufacturers storage conditions to MSH supported CCT sites in Kwara and Niger states by the third party logistics partner contracted by JSI/SCMS. Most of these facilities have been out-of-stock for close to a month and this contributed to the poor patient retention at these facilities

The table below illustrates the values of the temperature charted and reported by the facilities and agreed to, by the third party logistics at the time of delivery to the facility.

S/N	FACILITY	TYPE OF REAGENT	TEMPERATURE (DEGREE CELSIUS)
1	UITH	CYFLOW	5.2
2	SOBI SPECIALIST	BD FACS	13.2
3	CHILDREN SPECIALIST	BD FACS	22.3
4	CIVIL SERVICE	BD FACS	22.5
5	OFFA SPECIALIST	BD FACS	22.4
6	GH OMUARAN	BD FACS	8.3
7	GH LAFIAGI	BD FACS	10.1

MSH lab and SCMS team followed up with JSI/SCMS and a request to resupply CD4 reagents to all affected facilities was put through. Subsequently, all affected facilities received new supplies of CD4 reagents with the retrieval of the initial compromised supplies. The temperature of the reagents was at the time of delivery closely monitored and documented which showed that all were delivered in line with expected best practices (Specialist Hospital Offa - 5.20C; Specialist Hospital Sobi - 4.0C; General Hospital Omu-aran - 5.60C; Civil Service Hospital - 7.0C; Children Specialist Hospital - 4.40C; GH Lafiagi - 2.90C).

Next quarter plans

- Host a viral load optimization seminar (grand CME) for facility multidisciplinary teams that will be drawn from UDUTH and the other four CCT sites located within Sokoto metropolis, as a strategy to optimize VL test uptake as well as sensitize and link other sites to the UDUTH PCR lab.
- Intensify technical assistance to laboratories in tertiary health facilities in their preparedness towards institutionalizing quality management systems and preparedness towards accreditation as recently mandated by the FMOH.
- Sustain retrospective GenXpert data review across facilities with GenXpert capacity to assess utilization and uptake of services.

IR 3. Strengthen public, private and community enabling environments

The MSH Pro-ACT project works to achieve effective and efficient health systems in the five focus states to deliver sustainable HIV/TB and other related services through CSO, LACA, SACA and SMOH engagement and capacity development. Activities planned for Q2 focused mainly on providing technical support to hospital management teams, state government partners on human resources for health (HRH) and in addition to strengthening leadership and governance at the local government level. Key achievements in this quarter include the formal launch of the Kwara State health workforce registry, post transition assessment of PMTCT sites and improved collaboration between MSH and the Niger state Center for Health Professionals Continuing Education (CHPCE) which helped to enhance the operations of the center through collaboration in the delivery of training workshops and award of CPD points.

3.1 Strengthening health service delivery through development of facility operational plans for pilot health facilities

As part of the continued effort of the Pro-ACT project to address the challenges of inadequate funding, shortage in HRH, medicines, vaccines and technologies, and in a bid to strengthen the health systems at the health facility level, the project worked with the Hospital Services Management Board/Ministry of Health. The purpose of this partnership was the conceptualization and development of facility-specific operational plans that accurately reflects a shared vision of the hospital's senior management team to coordinate the hospital's resources (human, financial and physical) and systematically mobilizes resources from identified philanthropists and organized private sector to bridge the gap in resources and complement government efforts. In Q1, the process was conducted in Kwara (GH Offa and Civil Service Hospital Ilorin), Niger (GH Minna and GH Bida) and Sokoto (GH Tambuwal and GH Illela) states. The

following documents were developed for each facility:

- Operational plan narrative
- Costed operational plan
- Resource map
- Stakeholder analysis

In Q2, MSH continued to provide technical support to ensure that the operational plans developed are implemented. The development and implementation of facility operational plans for selected General Hospitals has helped improve the engagement between the hospital, and members of the community. In General Hospital Offa, philanthropists in the community have provided alternative energy supply, water supply, and carried out several reconstructions, with an estimated value of N500,000 (US\$2,525). Also, as part of the resource mobilization drive in General Hospital Tambuwal, Sokoto state, a facility-based initiative to generate income from patients by five departments (Outpatient Department, Pharmacy, Laboratory, ANC and labor/delivery) through user fees was developed. An estimated sum of N58,000 (US\$293) profit is generated monthly of which 95% is used to provide consumables required to sustain and improve services in the facility and 5% used to complement the government effort towards capital intensive projects in the facility.

3.2 PMTCT site post transition assessment

Following the successful transition of the first group of MSH supported PMTCT sites (37 sites with 0-4 positives) by the end of September 2015, a post transition assessment was conducted to evaluate their viability and assess the kind and level of support and services that have been sustained at the health facilities. Additionally the assessment was designed to identify gaps in the processes and quality of care related to ongoing PMTCT services, and to deliver new learnings as we strategize for phase 2 of the PMTCT transition.

Findings reveal that the facilities have continued to receive commodities (RTKs) from SCMS, PMTCT services have been sustained and data is being collected, collated and transmitted to the various states agencies for the control of AIDS. Areas of improvement for the Government of Nigeria would include re-training of the frontline health workers, mentoring of staff for improved capacity in completing the PMTCT cascade and data completeness.

2.2 Implementation Challenges

VIP clients

One of the key challenges that impacted program implementation in Q2 was the identification of a huge number of clients categorized as “VIP” clients at supported sites following a clinical care systems and patient file audit across the 41 supported sites. This audit revealed that a cohort of clients referred to as very important persons (VIPs) are one of major contributors to the poor retention rates observed in some health facilities. These VIP clients (provider relatives, celebrities, members of the political class) have, over time, developed personal relationships with hospital administrators, appointment staff, and some providers, and in most occasions are consulted privately on a VIP basis. Our audit findings further revealed

that these VIP clients sometimes did not make physical visits, but often called a designated staff member at the CCT site who would expedite the packaging of their ARV medications or a new appointment with the care provider at another location. As a result of this approach, VIP clients are not processed through the HIV clinic and consequently their data is not captured by the M&E unit, as their case files are not domiciled within the hospital filing system. A further site specific analysis revealed that this practice is most prevalent in 14 out of the 41 CCTs with the University of Ilorin teaching hospital (UIITH) contributing the highest number with 41 out of a total of 119 VIP clients identified thus far.

The table below illustrates the number of VIP clients in 14 out 41 facilities evaluated.

Site	No. of VIPs
FCM Gusau	2
GH Shinkafi	1
ASBSH	2
GH Minna	22
FMC Bida	20
FMPC	8
GH Bida	8
GH Omuaran	8
SSH Offa	1
SSH Sobi	1
UIITH	41
UDUTH	0
SHS	0
Satahaya	5
Total	119

3. M&E PLAN UPDATE

During the quarter under review, the M&E team continued to support activities that foster ownership and sustainability through collaboration with stakeholders in the state and service providers at health facility level. Specifically the M&E team sought to strengthen capacity of health facilities to generate, analyze and use HMIS information for hospital systems improvement and decision making. Also, the team continued to strengthen data documentation, reporting, and quality checks with the overall goal to improve the M&E system and enhance quality of service delivery in all supported health facilities.

In the quarter under review MSH had planned to launch the use of EMRS in three pilot sites, and this was achieved although retrospective data entry into the EMRS platform was not completed due to the high number and bulky nature of the patient case files. Also, the full deployment of EMR in the additional 16 health facilities was planned for this quarter but this was not achieved because of some procurement delays.

In this quarter, the M&E team supported the following activities across the project states:

- Mentoring and supportive supervision to health facilities for transfer of skills and to ensure quality data documentation and reporting for ownership and sustainability, including the new USG MER guidelines.
- Ongoing internal data quality assessment and validation of client using RADET tool.
- Strengthened electronic data documentation and reporting using OpenMRS and DHIS (e-NNRIMS) platform.
- Strengthened data quality across the states through regular technical assistance on proper data documentation
- Continuous liaison with clinicians in ensuring that client information is accurately documented in the ART care cards, and also with health facility personnel in populating the registers

3.1 Implementation of Electronic Medical Record System

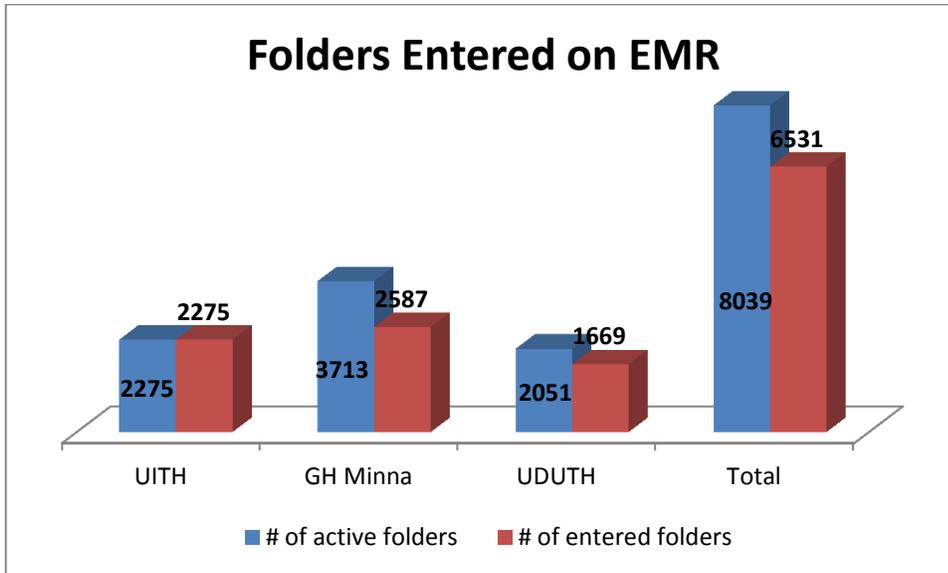
As part of ongoing efforts to strengthen the M&E system at the 41 partner health facilities, and following USAID’s approval, Pro-ACT began the process of transitioning from a paper based HMIS system to an electronic medical records system (EMRS) in FY15. This strategic decision was informed by several challenges currently being encountered with the paper based system such as poor storage conditions of the HMIS tools, mutilation of registers and forms, destruction of patients case files by rodents, delay in retrieval of patient case files, huge cost of printing and reprinting of the HMIS tools and lastly, frequent review of data sets to be captured and reported on by the USG Strategic Information (SI) team and National M&E TWG.

To move this process forward, MSH adopted a phased approach and in the pilot phase, three sites were selected for the deployment of the EMRS based on the fact that they had the highest volume of clients, and that the hospital management team had demonstrated a commitment to support the successful roll out of the platform. The three pilot health facilities are as outlined below:

- University of Ilorin Teaching Hospital (UIITH) Ilorin, Kwara state
- Usman Danfodiyo University Teaching Hospital (UDUTH) Sokoto State
- General Hospital (GH) Minna Niger state

During the quarter under review, the project team worked tirelessly to ensure that the EMRS went live and was active in time for use in FY16 SAPR reporting. The roll out process commenced with strategic engagement of relevant stakeholders at all levels to ensure facility team ownership and buy-in. This was quickly followed up with an EMR focused hands-on training of end users and relevant stakeholders. To safeguard these large investments, MSH identified and designated an EMR champion with great IT skills in each facility, and procured and installed inverters, as well as other hardware required for the successful implementation of the project. The EMRS has gone live in all three pilot sites and since its launch on the 1st of March 2016, preliminary feedback from service providers indicates that the platform is user friendly, has helped to streamline provider-patient interactions, and has had a positive impact on the overall patient care experience. For example, before the deployment of the EMRS, the average time to retrieve an active patient folder was 3 minutes while with the EMR, it now takes just 30 seconds.

Folders Entered on EMR



In all the three sites, folders of active patients have been entered in the system. In UITH all folders were uploaded while in UDUTH and GH Minna data entry will be completed this quarter. However, in all the three sites the EMR system is fully operational.

3.2 Challenges encountered in migrating from paper based to a digital platform

- Consistent interruption of power supply which became a hindrance in meeting up with the weekly target of digitizing 300 client folders. This resulted in a backlog of client folders but was resolved with the recruitment of additional short term EMR data entry clerks.
- The on-going strike action embarked upon by the resident doctors at UITH impacted the smooth roll out of the EMR due to the limited number of physicians on ground to offer clinical consultation using the platform. As a stop-gap measure, ART nurses were mentored to backstop pending when the strike action is called off.
- Local Area Network (LAN) and inverter cables were damaged during road rehabilitation work at the GH Minna and, as a result, some critical hospital units, such as the HTC unit where the EMR was deployed, were disconnected. Clients are currently not being captured but the MSH team is working through a cost-share mechanism with the hospital management to engage a vendor to restore network access.
- Given that this is a new experience, the facility staffs have yet to fully grasp the use of the platform and have continued to express concerns about high workload. To address this, MSH will continue to offer regular hands-on mentoring and supervision to improve staff skills.

3.3 Strengthening data documentation and reporting

Following the recently conducted data quality assessment carried out by USAID in 2 supported MSH health facilities in Niger State, the M&E team decided to replicate the same exercise in all MSH supported health facilities. The DQA exercise conducted by USAID was an eye opener for the project and some lessons were learned. As a result, MSH conducted internal DQA in all health facilities providing comprehensive HIV/AIDS services in five project supported states. The essence of this activity is to ensure that all MSH supported health facilities are up to speed with USAID and Government of Nigeria requirements. In the long run this will lead to improved program performance and more efficient resource management.

The exercise was conducted using our routine DQA tool but comparing with DQA tool used by USG team last quarter. The USG DQA considered 11 indicators in HTC, PMTCT, EID, care and treatment. The period considered during the exercise was fiscal year 15 (October 2014 to September 2015). Although, the tool is not designed as the regular DQA questionnaire format, consideration was given to all the M&E related issues ranging from availability, consistency, validity and systems. Based on USG DQA experience, the MSH M&E team considered their indicators in the adapted DQA tool to be better prepared for future USG DQA. It was recommended that all the identified issues be addressed by the state team with support from the M&E advisor before the end of the quarter. The team also conducted a data review meeting to review past performance, build capacity and develop strategies to strengthen the entire M&E system and improve program performance. The meeting had in attendance all the advisors, state team leads and M&E specialists.

Challenges Encountered

- Inability of some states to release funds to print HMIS tools that are out of stock. The state M&E team has been leveraging available HMIS tools from the state SACA. Minimal tool printing at state level has been recommended till we are certain that states are no longer able to print.
- Client retention: To address some of the documentation gaps in the health facilities, the M&E team is updating all forms and registers and also revalidating reported data.
- Electronic medical records: Long periods of power outages have resulted in inverter failure, which is affecting the retrospective data entry into the electronic platform (OpenMRS). MSH has been temporarily supporting the fueling of the generator in the ART clinic in UITH to address the challenge of power.

Next quarter plans

- Finalize ongoing cabling and networking of sites to ensure the timely scale-up of EMRS platform to additional 16 health facilities.
- Facilitate discussion with hospital leadership in designated EMR sites for the deployment of back-up power systems to minimize the impact of the epileptic power supply.
- Host a strategy review meeting to strengthen the M&E team's skills and knowledge base.
- Strengthen data documentation across the 41 partner health facilities through routine technical assistance to facility teams and support staff such as the data entry clerks.
- Conduct a data quality audit (DQA) in Q3.

4. INTEGRATION OF CROSSCUTTING ISSUES AND USAID FORWARD PRIORITIES

1. 4.1 Gender

Harmful gender norms can lead to risky behaviors, emotional, physical and sexual violence, substance abuse, and the pursuit of multiple sexual partners. These norms affect not only men and women, but also families and communities. Pro-ACT project gender interventions within the quarter under review primarily focused on identifying and addressing the structural and gender specific gaps which impede the uptake of HIV and AIDS services across all the supported health facilities and communities in the five project focus states of Niger, Kwara, Kebbi, Sokoto and Zamfara. Some of the strategies deployed to address the identified gaps include structural interventions to address harmful gender norms which impede service uptake among any particular sex.

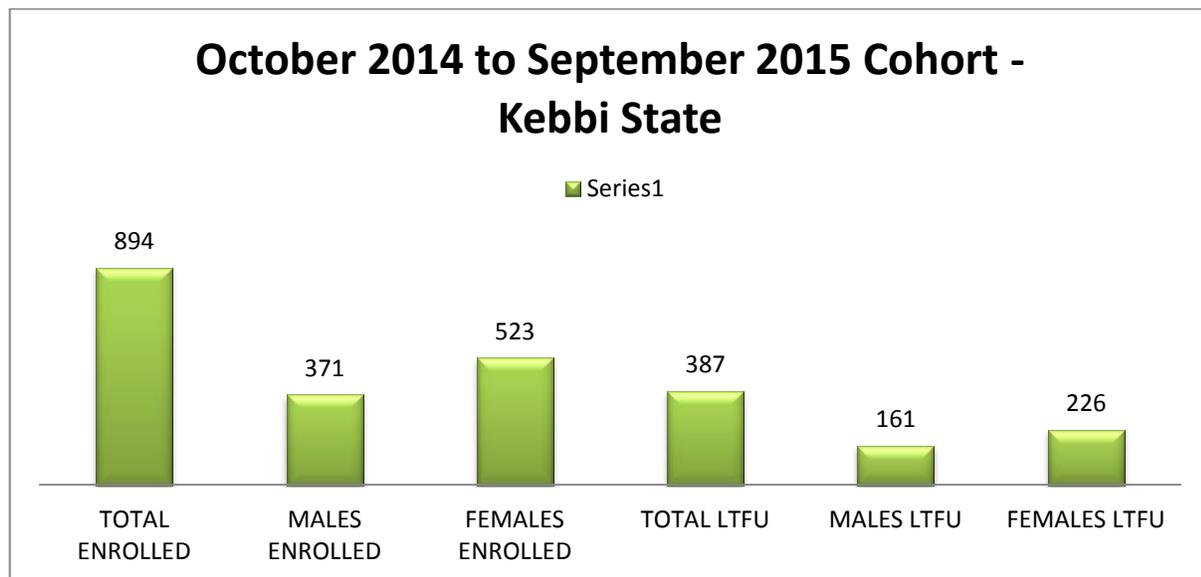
Gender norms/ Gender Based Violence (GBV) interventions

All gender related interventions under the Pro-ACT project are facilitated in collaboration with 5 PHDP grantee CSOs working across the five focus states. Within the quarter under review, a total of 647 community members comprised of 317 males and 330 females (98% increase compared to Q1) participated in community-based gender interventions facilitated through participatory focus group discussions. These discussions were tailored to address community specific harmful gender norms which hinder access to, and uptake of, HIV and AIDS prevention, treatment, care and support services. Gender focused interventions within Q2 were also tailored to address the increasing incidence of stigma and

discrimination against people living with HIV, early and forced marriage, as well as economic vulnerability of young women. As a direct result, 5 female victims of GBV were identified and linked to facility and community-based GBV services.

Gender analysis – October 2014 to September 2015 cohort of clients Lost to Follow-Up (LTFU)

Analysis of service data from a gender perspective has continued to be an integral part of the Pro-ACT project work. During the quarter under review, the team analyzed LTFU data from across all the five states. Findings from Kebbi state are illustrated in the chart below, which revealed that more women were LTFU than men enrolled after 12 months of initiation on ART. Pro-ACT will conduct an assessment to understand the unique factors that impact retention rates for both sexes, and will subsequently design interventions tailored to address these factors that may be uniquely different for each gender.



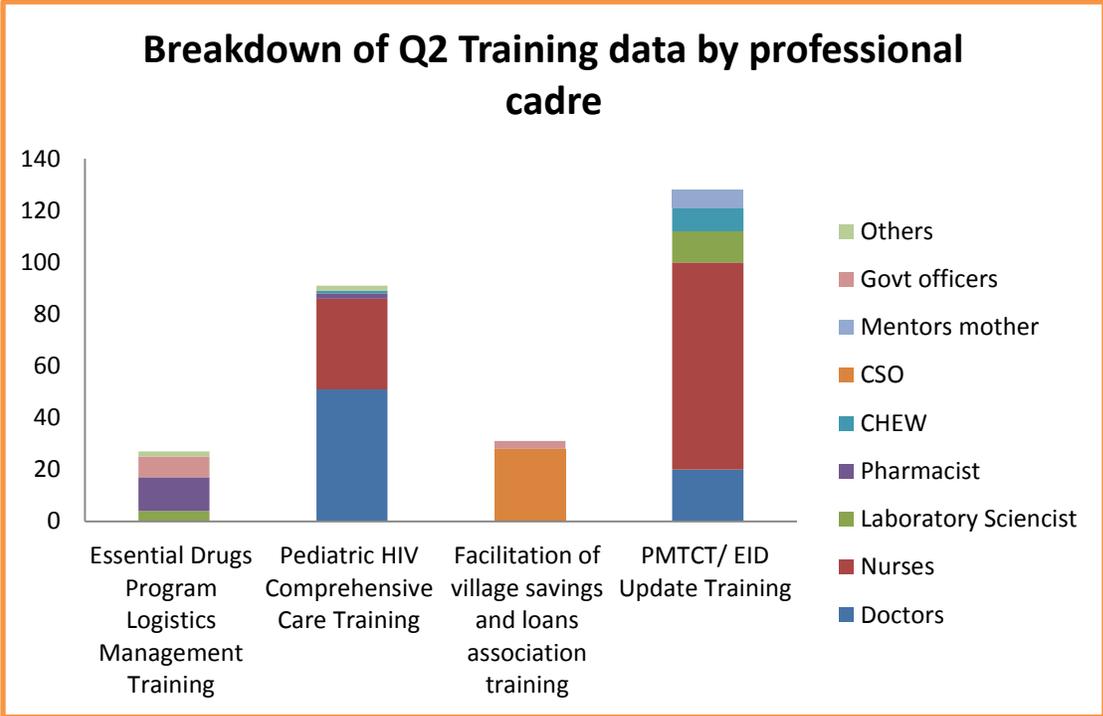
In Q3, MSH’s Pro-ACT gender focused interventions will continue to be targeted and tailored to the goal of narrowing gender gaps that put any gender in a disadvantaged position for accessing HIV services at partner health facilities. MSH will also seek to profile and mainstream gender across at all levels of service delivery (health facility and community), the analysis of issues will be informed by a consideration of gender differences and inequalities. Interventions will be tailored to identify and address gender norms and gender-based violence with an emphasis on meeting the minimum package of care.

2. 4.2 Sustainability Mechanisms

The Pro-ACT project has worked to develop a sustainability plan with the participation of all relevant levels of government and other major stakeholders in the focus states of Niger, Kwara, Kebbi, Sokoto and Zamfara. This plan clearly defines the levels of intervention and the amount of resources to be contributed by the project and by the government structures, with an increasing level of governmental contribution, and a gradual phase-out of MSH-led activities. In the final project year, we have noted some commitment by our state government partners and institutions to take responsibility for the ownership and sustainability of PEPFAR’s investment and two examples are highlighted in the section below.

Sustaining training of frontline health workers at PEPFAR-supported partner health facilities

In response to the challenge of a lack of a sustainable framework for building capacity of service providers at the sub-national level, Pro-ACT adopted a participatory and collaborative strategy to engage with the state government, which culminated in the provision of seed grants to 5 SMOHs for the establishment of Centers for Health Professional Continuing Education (CPHCE). The Centers are housed under the Medical Services and Training department of the SMOH and were supported to attain the status of Continuing Medical Education (CME) providers and registered with the various professional health councils having satisfied all the set criteria and guidelines. MSH Pro-ACT trained selected master facilitators across various cadres of health workers, with expertise on TB, HIV/AIDS, Malaria and project management, to make up the multi-disciplinary faculty responsible for managing the trainings. These trained faculties have been



tasked with the

responsibility of developing training curriculum and training schedules for facilitating continuous in-service training, retraining and collaborative learning among all the different cadres of health workers on HIV/AIDS, TB, Malaria and project management, as well as contributing to pre-service training curricula for health workers on the management of HIV/AIDS.

In the quarter under review, MSH continued to collaborate with the Centers in the training of frontline healthcare workers drawn from partner hospitals across the five focus states. State based master trainers were engaged to co-facilitate the PMTCT and ART training workshops, as well as the pediatric training workshop, and, as a direct result, CPD points were awarded to participants who were willing to pay a token fee.

A total of 277 frontline health care workers, CSO staff and state government partner staff were trained in Q2. A further breakdown shows that 27 pharmacists were trained on essential drug program logistics management, 91 health care workers on pediatric HIV care and treatment, 28 Civil Society Organizations (CSOs) staff and 3 government partner staff benefited from the Village Saving and Loans Association

(VSLA) training, and 128 health care workers were trained on the delivery of quality PMTCT and early infant diagnosis (EID) services.

The CHPCE model was created as a sustainability plan to transition MSH Pro-ACT HIV/AIDS capacity building program to the government agencies in the various focus states, and it has served to improve the institutional capacity of states to own, manage and coordinate continuous in-service trainings and retraining of health workers for enhanced performance and sustained improvement of health outcomes for the population.

Sustaining PEPFAR-Initiated Laboratory services through Laboratory Revolving Fund (LRF) programs

With the transition and discontinuation of PEPFAR funding support for chemistry and hematology investigations in October 2014, HIV positive clients enrolled at MSH supported health facilities have continued to access laboratory services at no cost due largely to the successful implementation of the laboratory revolving fund (LRF) program which is designed to be self-sustaining, being a cost recovery scheme.

MSH identified the LRF programs as a financing alternative that will sustain the provision of chemistry and hematology tests at no cost to PLHIV enrolled at supported sites, and over the past 18 months, have continued to provide TA to hospital management teams and laboratory units at partner health facilities, to strengthen the workings of the LRF program.

Great success has been achieved at the Sir Yahaya Memorial Hospital Birnin Kebbi, Kebbi state, a comprehensive site with an HIV patient volume of 3,012, which MSH has supported since 2013. With the cessation of PEPFAR funding support for chemistry and hematology investigations in October 2014, MSH worked closely with the hospital management and laboratory team, to redesign the existing LRF program with an overall goal of improving internally generated revenue. One year post implementation, the revenue base has significantly improved and, as a direct result, the facility has been able to procure laboratory reagents and consumables at a cost of N4,859,500 (\$24,694), and have continued to provide critical laboratory services to PLHIV enrolled in the center at no cost. The hospital management has continued to provide for planned preventive maintenance (PPM), which were hitherto undertaken by MSH, and repair of malfunctioning laboratory platforms. In this quarter under review, a financial investment of N272, 000 (\$1,374) was made to repair the Sysmex, and Mindre brand of hematology analyzers and also two chemistry analyzers in order to ensure uninterrupted laboratory service delivery. Additionally, a new chemistry analyzer was recently procured at a cost of N750,000 (\$3,788) to serve as a backup. These investments and achievements have been made possible through significant financial gains made since the redesign of the LRF, as well as the deployment of well-articulated financial management procedures and policies that makes it feasible for the hospital to track utilization of funds generated.

3. 4.3 Local Capacity Development

MSH Pro-ACT project has been providing fixed cost small grants to strengthen technical and organizational capacity of both CSOs, and state institutions as a strategy to ensure the sustenance HIV service-delivery points at the facility and in the community, continuously improve quality of services, improve capacity of

health workers, and enable them to promote and support a cadre of community facilitators and advocates. This is in line with PEPFAR and USAID Forward initiatives of strengthening local capacity for a sustained HIV response. Through this grants mechanism, MSH is currently supporting and collaborating with 5 PHDP and 9 OVC CSO grantees across the focus states to sensitize communities on OVC care and rights, economically empower care givers and older OVC to provide sustainable care, and support vulnerable children. Working collaboratively with MSH teams, the CSO grantees are expected to graduate households out of the project as they attain better vulnerability status in FY16.

Strengthening organizational & technical capacity of CSOs to deliver and monitor quality community-based PHDP and OVC services

As the CSO grantees take up their roles and responsibilities of service provision, the project grant team conducted a supportive and mentoring visit to improve quality of service delivery and also to determine grant compliance, prevent/identify deficiencies, build capacity, and design corrective actions to improve or reinforce program objectives, as well as ensure accomplishments of the desired results.

A total of 14 CSO grantees were visited during the quarter under review, across the 5 project states with key areas of focus as outlined below:

- Governance and leadership structure
- Financial management and internal control
- Procurement policies and practice
- Resource mobilization and sustainability plan
- Organization’s human resource policies and practice
- Organizational networking plan

Through the quarterly supervisory and mentoring visit to grantee CSOs, the project has proposed trainings on governance for board members of the non-government organizations and financial management alongside other technical training on OVC and PHDP for the sub-grantees. This is to enhance sub-grantees capacity and enhance quality of OVC and PHDP services. Additionally, 14 organizational improvement plans were developed to address all identified gaps holistically. MSH will continue to support the implementation of these plans in Q3.

Illustrated in the table below is a list of civil society organization (CSO) grantees whose grants were renewed in November 2015 to provide Orphans and Vulnerable Children (OVC) services in targeted LGAs.

S/No	Name Of OVC focused CSO	State	Coverage LGAs
1	Health Development Agency (Child To Child)	Niger	Bida, Gbako And Lavun
2	Community Life Advancement Project (CLAP)	Niger	Gurara, Lapai, Chanchaga, Paikoro And Bosso
3	Hope For Family Development Initiative (HFDI) Kwara	Kwara	Ilorin-South, Ilorin-East And Ilorin-West, Offa
4	Future Hope Foundation (FHF) For The Less Privilege	Zamfara	Gusau
5	Fulani Initiative For Protection Of Environment And Less Privileged (FUPEL)	Zamfara	Maradun

6	Nagarta Community Health And Gender Education Initiative (CHANGE Initiative) Sokoto State	Sokoto	Dange/Shuni
7	Integrated Life Support For Women & Children Initiative (ILSWACI)	Sokoto	Sokoto South
8	Jama'a Community Development Initiative	Sokoto	Yabo
9	Kungiyar Tallafin Mata Development Initiative	Kebbi	Argungu

4.4.4 Science, Technology, and Innovation Impacts

With the introduction and strengthening of electronic health information systems for comprehensive HIV care and treatment services through PEPFAR support, HIV-related health data have become increasingly available in digital formats in Nigeria.

Since inception in 2009, all of the MSH Pro-ACT supported sites in the five focus states had maintained paper-based medical records which have posed a challenge as the HIV chronic care model requires clients to be on lifelong ART. Furthermore, the associated clinical management requires documentation of all clinical encounters, laboratory investigation results, and medications prescribed and dispensed based on each clinic visit. Over time, the volume of HIV positive clients accessing care in most MSH supported facilities exceeded 1,000 making it extremely challenging for the multidisciplinary team of clinicians to provide quality services. On the program side, most times obtaining patient level data to analyze and inform program decisions was also challenging.

Given the increasing number of clients, the expected large volume of patient level information to be collected from clients when required, and the need for regular and efficient

DASHBOARD HEADER

Dashboard Header is where the patient name, ID's, age etc. are located for quick view by the provider. Below the dashboard header a quick view of patient Last Visit, BMI, Height, Weight and most recent Lab information (if any) and Current regimen likewise can be visible.

PROGRAM ENROLLMENT

- ✓ Select a program from the drop-down list provided under Overview tab.
- ✓ Enter enrollment date by selecting from the date picker.
- ✓ Choose a facility name.
- ✓ Select an initial state (optional) and Click Enroll to save the program enrollment form.

Screen shot of the EMRS

** OpenMRS is a collaborative open source project to develop software to support the delivery of health care in developing countries. OpenMRS is founded on the principles of openness and sharing of ideas, software and strategies for deployment and use. The system is designed to be usable in very resource poor environments and can be modified with the addition of new data items, forms and reports without programming. It is intended as a platform that many organizations can adopt and modify avoiding the need to develop a system from scratch. It grew out of the critical need to scale up the treatment of HIV in Africa but from the start was conceived as a general purpose electronic medical record system that could support the full range of medical treatments.*

monitoring, USAID approved for MSH to deploy Electronic Medical Record Systems (EMRS). EMRS was deployed across 19 supported sites as it was evident that an EMRS would offer significant benefits for both patient clinical care and program management. Additionally, it was anticipated that an efficient EMR platform will significantly ease the burden of data collation and submission during the semi and annual progress reporting cycles. Furthermore, there was also a general consensus internally, that the initiation of an EMRS would allow for operational monitoring and evaluations that would be useful for our continuous quality improvement efforts.

Through a sub-contract agreement, MSH M&E team collaborated with an EMRS experienced PEPFAR implementing partner, the CDC-funded Institute of Human Virology Nigeria (IHVN), to develop a comprehensive plan for the phased implementation of the EMRS in the designated sites, starting with three pilot sites. A phased approach was agreed to because of significant infrastructure challenges identified such as inadequate space to house the server room, non-availability of internet access and uninterrupted electrical supply at these sites.

One of MSH Pro-ACT's project goals is to support and develop systems for sustainable HIV care and treatment services accordingly. The choice was made to deploy OpenMRS as the software of choice with the recognition that the program would eventually be transitioned to our state government partners. Furthermore, the decision to move forward with OpenMRS was informed by the need to avoid a platform that required highly specialized training or expensive software developers for modifying the databases, or had barriers, such as high cost or maintenance fees. Other considerations that weighed heavily in the design of the EMRS and choice of OpenMRS included: user-friendliness, and a platform that can be used by a wide variety of end users (e.g. clinicians, data entry clerks, pharmacists and laboratory staff who were used to and familiar with paper-based clinical forms and registers). Significant differences in how the HIV clinics were organized and the physical distance to other key hospital units such as the laboratories, pharmacies, and records unit, and adaptability and sustainability of its use over time were also factors.

The EMRS, when fully deployed across the 19 health facilities, would improve the Health Management Information Systems (HMIS) and will provide for a more efficient way in managing patient information and analysis of program data.

5. STAKEHOLDER PARTICIPATION AND INVOLVEMENT

Increasing the fiscal space for HIV/AIDS through capacity building of health managers on the use of the OneHealth Tool

Following the new zero-based budgetary system introduced in the country, the project supported a 3-day residential training on the OneHealth tool for health planners in the 5 Pro-ACT supported states. The tool is software designed to aid strategic health planning, particularly in low- and middle-income countries.

This tool provides planners with a single framework for scenario analysis, costing, health impact analysis, budgeting, and financing of strategies for all major diseases and health system components. It is primarily intended to inform sector wide national and sub-national strategic health plans and policies.

A total of 20 participants from the states were trained. These included the Directors of Planning, Research and Statistics, State Epidemiologists, Project Managers from SACA, M&E officers from the State Ministries of Health, and health planners from the State Ministry of Budget and Economic Planning. The skills acquired at this training will improve the quality and efficiency of the 2016 budget process for health and HIV/AIDS in particular.

Deployment of State Health Workforce Registry

To strengthen the management of human resource systems at the subnational level, MSH worked with relevant stakeholders in Kwara state to develop and customize a state based health workforce registry that resulted in the deployment of a functional Human Resource Information System (HRIS) that is aligned and integrated with the National Health Workforce Registry. Following the successful completion of the digital registry, MSH trained health managers, data entry officers, and HRH desk officers on how to manage and use the platform.

On February 17, 2016, MSH launched the National Health Workforce Registry in Ilorin, the state capital. This launch was in line with the directive from the Nigerian National Policy on Human Resources for Health mandating all 36 state ministries of health to develop a functional electronic and web-based National Health Workforce Registry, and deploy this open source application for the digitalization of state health workforce data. The platform manages and tracks HRH data that can be analyzed to make informed decisions. Within the quarter, health managers, data entry officers, and HRH desk officers were trained on the management of the platform. The e-registry would improve efficiency in HRH issues in the state and would enhance transparency in HRH management.

Partnership and collaboration with the State Agency for the Control of AIDS to strengthen the M&E system

MSH's monitoring and evaluation unit has continued to support the M&E system through strengthening the existing government structures in supported states. We have continued to work with the local government, SACA, SMOH M&E officers and the M&E technical working groups. The collaboration has been through meetings, technical assistance, joint site visits, training, human resources and financial support.

This is a key M&E deliverable on the Pro-ACT project. The whole essence of strengthening the M&E system is to ensure that the state can deliver these functions without support from any implementing partner. We have achieved so much in the area of collection and collation but we have not achieved so much in the areas of analysis and data use, which are very critical. As a result, we conducted refresher training for health facility M&E officers which will help to strengthen the M&E system. To deliver on the above result, we have continued to transfer skills through regular site visits and hands-on mentoring. We have continued to support the state to generate quality data through the use of national tools, capacity building and mentoring of state government employed staff.

The partnership has yielded positive results in the area of HMIS tools. Most of the HMIS tools have been leveraged from the state government through SACA however, there has been a setback this FY since the states stopped printing tools, and we are hoping they will continue following targeted advocacy.

Notwithstanding there is still collaboration in the areas of human resources, commodities and power supply through fueling of electricity generating sets.

Support to national level M&E activities

The National AIDS/STI Control Program in collaboration with National Agency for the Control of AIDS (NACA) and other stakeholders, convenes a bi-annual data validation workshop for verifying HIV/AIDS health sector data. The workshop avails stakeholders the opportunity of reviewing data generated at the states to ensure that Nigeria's report is of high quality and can be trusted for informed decision making, program planning and implementation. MSH, being a key stakeholder, was invited to support the workshop. The workshop was zoned into the geo-political zones. MSH, who currently supports the governments of some states in the North West and north central zones, was meant to be in Kaduna and Ibadan venues. MSH only participated in the north central zone which was held in Kaduna but was unable to participate in the North West zone due to other competing project priorities.

6. MANAGEMENT AND ADMINISTRATIVE ISSUES

In the last six months the project has suffered a high staff turnover particularly in the 3 states of Kebbi, Zamfara and Sokoto. During this period, a total of 14 staff have left the project. Results from the analysis of staff exit interviews point to several factors why staff are leaving. These include the impending end of the project, working conditions and better opportunities in other organizations.

MSH is committed to retain its staff for as long as possible and the organization is taking measures to ensure that we retain our critical staff till the project end date. These measures include re introducing incentives for staff who work in hard to live areas, assuring staff that the End of Project Bonus will be paid to staff who stay up to the end and also working on ensuring that our staff compensation remains as competitive as that of other implementing partners.

7. UPCOMING EVENTS

MSH plans to officially launch the EMRS initiated at General Hospital (GH) Minna Niger state in Q3. The key objective of this launch is to increase USAID visibility and showcase the continued support of the American people and US government in improving existing health information management systems through the upgrade from a paper based HMIS to an electronic system using OpenMRS. Additionally, the launch will provide a platform to advocate for continued support from the state government in the maintenance and sustenance of this investment which came at a huge cost.

A similar launch will be planned for and held in the other two states of Sokoto and Kwara where the EMRS is live and active.

8. WHAT DOES USAID NOT KNOW THAT IT NEEDS TO?

While we have made some progress in advocating for targeted testing by the facilities, and also in our efforts of transitioning responsibility for some HIV services to state governments, the SCMS program has continued to supply commodities, especially test kits, basing on the Combined Report Requisition Issue receipt Form (CRRIRF), returns even to already transitioned sites. This unrestricted supply undermines both the efforts being made to mobilize resources from government and those made to ensure facilities follow the targeted testing guidance. If RTKs for all facility testing needs are provided, and these needs are based on the assumption of testing everybody, there will be no “incentive” for restricting the testing to priority clients, and there will be no gap for which governments will need to provide resources to fill.

ANNEX A: Success Story

MSH Empowers PLHIV Economically - The Story of Ronke

By Olukunle Omotoso



Photo of Ronke Taiwo (alias). (Photo: MSH Staff)

Ronke Taiwo (not her real name) is a 45 year old woman who lives with her husband and five children in Omuaran, Irepodun local government area in Kwara State, Nigeria.

Ronke and her husband manage a small patent medicine shop and earn about 2,000 naira (\$10) per month. Supporting her family on this income has been difficult. Ronke is HIV positive and a member of a support group in Kwara called *Alaafia Tayo* (meaning “There’s joy in good health”) supported by the PEPFAR-USAID funded Prevention Organizational Systems AIDS Care and Treatment (Pro-ACT) project.

To economically empower people living with HIV who are members of the support group, Pro-ACT selected Ronke and three other women from the support group and trained them on how to set up and successfully manage a Village Saving and Loans Association (VSLA). The goal is for these women to be able to provide for their families without relying on the monthly stipends MSH has been supporting them with since 2009. The women were trained in Minna, Niger state in September 2014 to set up VSLAs in their communities as an Income Generating Activity (IGA) for its members.

Two weeks after the training, Ronke facilitated the formation of a 13-member VSLA called *Alaafia Tayo*. Members meet once in a month and make monthly contributions of 500 naira each. By December 2015, members had contributed N150, 000 (\$750). Members can access a loan of N10,000, repayable monthly within 10 months with an interest of N20 on every N1,000. Eleven months after *Alaafia Tayo* was formed, Ronke and other members started accessing loans to improve their businesses.

Ronke said that before the establishment of the VSLA, she used to buy medicines at retail value and resell them at a slight markup. With her loan, her profit has increased because she can now buy larger quantities of medicines at wholesale prices, and sell them to other patent medicine vendors in her community. She makes a monthly profit of 5,000 naira (\$25), which is half the value of the loan she got from the VSLA. Ronke, who is also the coordinator of *Alaafia Tayo* and an advocate of the VSLA, has been encouraging other PLHIV in her community to join the association and gain financial independence.

“I am so happy that the VSLA has afforded me the opportunity to improve my business. More PLHIV have joined our support group in Omuaran, and the association has enabled us to provide for the needs of our families,” said Ronke.

ANNEX B: State Summary Performance Tables

I. Summary of Kebbi State Performance

Performance Indicators	State Annual Cumulative Planned target	Annual Cumulative Actual	Q1	Q2	Annual Performance Achieved to the end of reporting period (in %)	On Target Y/N
# of pregnant women with known HIV status (includes women who tested for HIV and received their results)	28,067	12830	6503	6327	46%	Y
# of pregnant women tested +ve to HIV(including Known positive)	188	102	55	51	54%	Y
# of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission(Numerator)	179	84	48	36	47%	Y
# of infants born to HIV-positive pregnant women who received an HIV test within 12 months	179	107	47	60	60%	Y
# of exposed infants who received prophylaxis after delivery.		64	42	22		
Output: Number of individuals who received testing and counseling services for HIV and received their test results (including PMTCT)	54,600	38321	20755	17566	70%	Y
Output: Number of individuals who were tested positive to HIV(including PMTCT)	1,774	966	494	472	54%	Y
# of HIV positive adults and children who received at least one of the following during the reporting period: clinical assessment (WHO staging) OR CD4 count OR viral load (DSD)	4,408	2819	2187	2819	64%	Y
# of HIV-infected adults and children newly enrolled in clinical care during the reporting period and received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	854	748	364	384	88%	Y
# of HIV-positive patients who were screened for TB in an HIV care or treatment settings(Numerator)	4,320	916	442	474	21%	N
% of adults and children who are still	85%	54%			54%	N

alive and on treatment at 12 months after initiating ART(Numerator)						
# of adults and children with advanced HIV infection <u>newly</u> enrolled on ART	684	636	327	309	93%	Y
# of adults and children with advanced HIV infection receiving antiretroviral therapy (ART) [CURRENT]	3,526	3842	3903	3842	109%	Y

2. Summary of Kwara State Performance

Performance Indicators	State Annual Cumulative Planned target	Annual Cumulative Actual	Q1	Q2	Annual Performance Achieved to the end of reporting period (in %)	On Target Y/N
# of pregnant women with known HIV status (includes women who tested for HIV and received their results)	20,189	14044	7095	6949	70%	Y
# of pregnant women tested +ve to HIV(including Known positive)	261	258	135	123	99%	Y
# of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission(Numerator)	248	232	122	110	94%	Y
# of infants born to HIV-positive pregnant women who received an HIV test within 12 months	248	109	43	66	44%	N
# of exposed infants who received prophylaxis after delivery.		164	81	83		
Output: Number of individuals who received testing and counseling services for HIV and received their test results (including PMTCT)	55,531	27687	14523	13164	50%	Y
Output: Number of individuals who were tested positive to HIV(including PMTCT)	1,804	1022	517	505	57%	Y
# of HIV positive adults and children who received at least one of the following during the reporting period: clinical assessment (WHO staging) OR CD4 count OR viral load (DSD)	5,134	5789	5053	5789	113%	Y
# of HIV-infected adults and children newly enrolled in clinical care during the reporting period and received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	938	658	312	346	70%	Y
# of HIV-positive patients who were screened for TB in an HIV care or treatment settings(Numerator)	5,035	4444	3688	756	88%	Y

% of adults and children who are still alive and on treatment at 12 months after initiating ART(Numerator)	85%	74%			74%	N
# of adults and children with advanced HIV infection <u>newly</u> enrolled on ART	750	634	332	302	85%	Y
# of adults and children with advanced HIV infection receiving antiretroviral therapy(ART)[CURRENT]	4,108	4995	4947	4995	122%	Y

3. Summary of Niger State Performance

Performance Indicators	State Annual Cumulative Planned target	Annual Cumulative Actual	Q1	Q2	Annual Performance Achieved to the end of reporting period (in %)	On Target Y/N
# of pregnant women with known HIV status (includes women who tested for HIV and received their results)	45,150	37776	19261	18515	84%	Y
# of pregnant women tested +ve to HIV(including Known positive)	853	662	334	332	78%	Y
# of HIV-positive pregnant women who received antiretroviral to reduce risk of mother-to-child-transmission(Numerator)	810	633	332	301	78%	Y
# of infants born to HIV-positive pregnant women who received an HIV test within 12 months	810	146	190	23	18%	N
# of exposed infants who received prophylaxis after delivery.		526	279	247		
Output: Number of individuals who received testing and counseling services for HIV and received their test results (including PMTCT)	110,982	89183	45379	43867	80%	Y
Output: Number of individuals who were tested positive to HIV(including PMTCT)	3,605	3043	1476	1570	84%	Y
# of HIV positive adults and children who received at least one of the following during the reporting period: clinical assessment (WHO staging) OR CD4 count OR viral load (DSD)	15,459	11252	8952	11252	73%	Y
# of HIV-infected adults and children newly enrolled in clinical care during the reporting period and received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	3,188	2177	1128	1049	68%	Y
# of HIV-positive patients who were screened for TB in an HIV care or treatment settings(Numerator)	15,155	10427	8279	2148	69%	Y

% of adults and children who are still alive and on treatment at 12 months after initiating ART(Numerator)	85%	65%			65%	N
# of adults and children with advanced HIV infection <u>newly</u> enrolled on ART	2,551	1799	923	876	71%	Y
# of adults and children with advanced HIV infection receiving antiretroviral therapy (ART) [CURRENT]	12,368	14751	14273	14751	119%	Y

4. Summary of Sokoto State Performance

Performance Indicators	State Annual Cumulative Planned target	Annual Cumulative Actual	Q1	Q2	Annual Performance Achieved to the end of reporting period (in %)	On Target Y/N
# of pregnant women with known HIV status (includes women who tested for HIV and received their results)	13,034	10693	5258	5396	82%	Y
# of pregnant women tested +ve to HIV(including Known positive)	131	107	57	50	82%	Y
# of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission(Numerator)	124	101	54	47	81%	Y
# of infants born to HIV-positive pregnant women who received an HIV test within 12 months	124	218	115	103	176%	Y
# of exposed infants who received prophylaxis after delivery.		56	24	32		
Output: Number of individuals who received testing and counseling services for HIV and received their test results (including PMTCT)	28,226	19800	9227	10443	70%	Y
Output: Number of individuals who were tested positive to HIV(including PMTCT)	917	770	403	366	84%	Y

# of HIV positive adults and children who received at least one of the following during the reporting period: clinical assessment (WHO staging) OR CD4 count OR viral load (DSD)	5,119	4319	3392	4319	84%	Y
# of HIV-infected adults and children newly enrolled in clinical care during the reporting period and received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	941	650	308	342	69%	Y
# of HIV-positive patients who were screened for TB in an HIV care or treatment settings(Numerator)	5,018	3649	2936	717	73%	Y
% of adults and children who are still alive and on treatment at 12 months after initiating ART(Numerator)	85%	65%			65%	N
# of adults and children with advanced HIV infection <u>newly</u> enrolled on ART	752	466	243	223	62%	Y
# of adults and children with advanced HIV infection receiving antiretroviral therapy(ART CURRENT)	4,095	4357	4535	4357	106%	Y

5. Summary of Zamfara State Performance

Performance Indicators	State Annual Cumulative Planned target	Annual Cumulative Actual	Q1	Q2	Annual Performance Achieved to the end of reporting period (in %)	On Target Y/N
# of pregnant women with known HIV status (includes women who tested for HIV and received their results)	15,995	17683	8308	9375	111%	Y
# of pregnant women tested +ve to HIV(including Known positive)	80	125	52	73	156%	Y
# of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission(Numerator)	76	119	51	68	157%	Y
# of infants born to HIV-positive pregnant women who received an HIV test within 12 months	76	115	50	65	151%	Y
# of exposed infants who received prophylaxis after delivery.		58	28	30		
Output: Number of individuals who received testing and counseling services for HIV and received their test results (including PMTCT)	25,075	38610	19667	18943	154%	Y
Output: Number of individuals who were tested positive to HIV(including PMTCT)	2,064	702	372	330	34%	Y
# of HIV positive adults and children who received at least one of the following during the reporting period: clinical assessment (WHO staging) OR CD4 count OR viral load (DSD)	1,030	2148	1855	2148	209%	Y
# of HIV-infected adults and children newly enrolled in clinical care during the reporting period and received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	217	331	174	157	153%	Y
# of HIV-positive patients who were screened for TB in an HIV care or treatment settings(Numerator)	1,010	1285	1053	232	127%	Y
% of adults and children who are still alive and on treatment at 12 months after initiating ART(Numerator)	85%	68%			68%	N

# of adults and children with advanced HIV infection <u>newly</u> enrolled on ART	173	307	147	160	177%	Y
# of adults and children with advanced HIV infection receiving antiretroviral therapy (ART) [CURRENT]	825	1753	1735	1753	212%	Y